HOUSE OF COMMONS Session 1991–92

HEALTH COMMITTEE

Second Report

MATERNITY SERVICES

Volume I

Report together with Appendices and the Proceedings of the Committee

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Ordered by The House of Commons *to be printed*
13 February 1992

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The Health Committee is appointed under SO No 130 to examine the expenditure, administration and policy of the Department of Health, associated public bodies and similar matters within the responsibilities of the Secretary of State for Northern Ireland.

The Committee consists of eleven Members, of whom the quorum is three.

The Committee shall have power:

(a) to send for persons, papers and records, to sit notwithstanding any adjournment of the House, to adjourn from place to place, and to report from time to time;

(b) to appoint persons with technical knowledge either to supply information which is not readily available or to elucidate matters of complexity within the Committee's order of reference;

(c) to communicate to any such other Committee, or the Public Accounts Committee, its evidence and other documents relating to matters of common interest; and

(d) to meet concurrently with any such other Committee for the purposes of deliberating, taking evidence, or considering draft reports.

Unless the House otherwise orders, all Members nominated to the Committee continue to be members of the Committee for the remainder of the Parliament.

Monday 21 January 1991

The following were nominated as Members of the Committee:

Mr Tom Clarke
Mr James Couchman
Mr Jerry Hayes
Mr David Hinchliffe
Alice Mahon
Sir David Price
Mr Andrew Rowe
Mr Roger Sims
Rev Martin Smyth
Mr Nicholas Winterton
Audrey Wise

Mr Nicholas Winterton was elected Chairman on Wednesday 30 January 1991.

Mr Jerry Hayes was discharged and Sir Anthony Durant was added on 10 February 1992.

The cost of printing and publishing this Report is estimated by Her Majesty's Stationery Office at £7,680.

TABLE OF CONTENTS

References throughout this Report to evidence taken orally are indicated by 'Q' followed by the question number. References to written evidence are given either to the evidence volumes (HC (1990-91) 430-II and III; HC (1991-92) 29-II and III)) as 'Ev.' followed by a page number; or to the index no. of the memorandum received, indicated by the prefix 'MS'. A list of memoranda received, in numerical order, is printed at the back of this Report, showing in which volume, if it has been printed, the memorandum is located. Unpublished memoranda (indicated by an asterisk) are available for public inspection in the Record Office of the House of Lords.

SECOND REPORT

MATERNITY SERVICES

The Health Committee has agreed to the following Report:

INTRODUCTION

1. What happens in pregnancy, birth and the early weeks of life is of the utmost importance to all of us.

2. The Committee was stimulated into conducting this inquiry by its awareness of the fact that it is now over a decade since the last major inquiry into these matters by the then Social Services Committee, and by hearing many voices saying that all is not well with the maternity services and that women have needs which are not being met.

3. Such discontent may seem paradoxical in view of the continued fall in perinatal mortality, and the very low levels of maternal mortality. However, although avoidance of death is very important, it cannot be the only determinant of satisfactory maternity services. We set out on this inquiry with the belief that it is possible for the outcome of a pregnancy to be a healthy mother with a healthy, normal baby and yet for there to have been other things unsatisfactory in the delivery of the maternity care. Women want a life-enhancing start to their family life, laying the groundwork for caring and confident parenthood, and we set out to discover if this is what they obtain.

4. Becoming a mother is not an illness. It is not an abnormality. It is a normal process which occurs during the lives of the majority of women and can indeed be seen as a manifestation of health. It is physically very demanding and is a time when women are vulnerable in many ways. They require help and support during the process of being pregnant, giving birth, and postnatally and some of this, though not all, needs professional help. In some circumstances the quality of the professional help is literally vital. But it is the mother who gives birth and it is she who will have the lifelong commitment which motherhood brings. She is the most active participant in the birth process. Her interests are intimately bound up with those of her baby.

5. For all these reasons we made normal birth of healthy babies to healthy women the starting point and focus of our inquiry. Getting this right is vital for society as a whole and has a fundamental bearing on the quality of life of most women and their families.

6. Sadly, there are those for whom things go wrong. Nature is not perfect, babies sometimes die, and others are disabled or unhealthy. It is the responsibility of the maternity services to minimise such occurrences, and to treat the babies and their parents well and reduce their suffering when possible. Having normality and health as our main focus, we have nevertheless devoted considerable attention to those facing problems or unhappy outcomes.

7. An important consideration which we have borne in mind is the need to ensure that the resources devoted to the maternity services are not only adequate but cost-effectively used.

8. We hope this report will be found valuable by mothers, fathers, and all the relevant professionals, that it will receive a favourable response from government, and that the fundamental nature of its recommendations will be a spur to action to improve the maternity services.

9. The predecessor of this Committee, the Social Services Committee, produced three reports in its lifetime on perinatal, neonatal and infant mortality.[1] The focus of concern in these reports was a drive to reduce the levels of mortality for children during and after birth. However, in the last of the reports the Committee stated 'we believe that maternity and obstetric services should be considered as a whole, and not exclusively in terms of their impact on mortality'.[2] The inquiry conducted by the Health Committee which has led to this Report is its response to that challenge to consider maternity services 'as a whole'.

10. Since the inquiry was announced in April 1991, the Committee has received a flood of memoranda, letters and other representations now numbering over 400. Many have been from organisations and individuals representing mothers rather than professionals. The scale and nature of that response underlines the extent to which mothers and their families are full partners in the maternity services; and that fundamental conviction has determined the Committee's whole approach to the gathering and evaluation of evidence in this inquiry.

11. In conducting this inquiry we have benefited from the specialist advice of Ms Caroline Flint, an independent midwife; Mrs Rosemary Jenkins of the Royal College of Midwives; Dr Naren Patel, Consultant Obstetrician at Ninewells Hospital, Dundee; Professor Osmund Reynolds, Professor of Neonatal Paediatrics at University College and Middlesex School of Medicine;

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[1]Second Report, Session 1979-80, HC 633-I; Third Report, Session 1983-84, HC 308; First Report, Session 1988-89, HC 54
[2]HC (1988-89) 54, p. vi

Professor Philip Steer, Professor of Obstetrics and Gynaecology at Charing Cross and Westminster Medical School; and Dr Luke Zander, Senior Lecturer in the Department of General Practice at the United Medical and Dental School of Guy's and St Thomas's. We wish to express our gratitude to them for undertaking a very onerous task. We have also made a number of visits in the UK and the rest of Europe which are listed in Appendix 1, and we are very grateful to our hosts and others we met on these occasions for the invaluable assistance they gave in enabling us to see maternity care in action. We also wish to thank the enormous number of people who have assisted us with written and oral evidence in this inquiry.[3]

12. In the last Session of Parliament we published a prefatory report on this inquiry into preconception services.[4] When we originally announced this inquiry it was intended that there should be five separate reports covering preconception, antenatal care, intrapartum care, postnatal care and neonatal care. Partly for this reason, many of the witnesses submitted their evidence under one or more of those headings. While preconception care and to some extent the neonatal services (which are the main subject of Chapter IV) can be studied in isolation, it will be clear from the rest of this report why we considered that it would be inappropriate to proceed in accordance with that original plan. References to the evidence therefore include references to that published in volumes II and III of the Preconception report, which included questions 1 to 796 and pages 1 to 336. The question numbers and page numbers of the evidence volumes published together with this report run sequentially to these.

13. In the first chapter of the report we review briefly the processes which have led to the present pattern of maternity care in this country with particular reference to the various inquiries and reports which are seen to have influenced developments in this century, and especially since the creation of the NHS. We consider some conflicting interpretations of this history, about which we have received considerable evidence, and draw conclusions. We then review the evidence we have received from women themselves and from organisations representing them about what they want from the maternity services of the NHS, and in the following chapter from the various professions involved in these services about what they believe mothers and babies both want and need. We then consider how the neonatal and other regional services, which have been the focus of previous reports, are faring. Finally we consider how maternity services can be organised in a way which succeeds in marrying the needs and desires of women and their families with the views of the professions on how those services should be provided; and recommend the steps which need to be taken to achieve that goal.

CHAPTER I: POLICY DEVELOPMENTS IN THE MATERNITY SERVICES

14. In the first decade of this century, the attention of the public, professionals and policy makers was focused on infant mortality as part of a wider concern about public health. This concern was associated with a fall in the infant mortality rate from 154 per thousand live births in England and Wales in 1900, to 105 per 1,000 in 1910 and 80 per 1,000 in 1920. In 1990 the rate had fallen to an all time low of 8.4 per 1,000. Maternal mortality proved to be a much more difficult problem. In 1918 the maternal mortality rate was 3.79 per 1,000 live births, a figure which had stubbornly refused to fall over the previous 50 years. Indeed, by 1934 the figure had risen to peak at 4.6 per 1,000 births. It started to fall after 1936, when powerful new drugs to fight sepsis became available. In 1990, the rate was 0.081 per thousand maternities.[5]

15. In the early part of the century, in response to public pressure from the Women's Co-Operative Guild and others, the Government started to fund schemes for maternal and child welfare, including home visiting of expectant mothers and newborn babies, home helps, and maternity centres with antenatal and child welfare clinics and in-patient beds. The 1907 Notification of Births Act gave the Local Government Board powers to give grants to local authorities and voluntary bodies to provide these schemes, and the powers were extended in 1915 under the Notification of Births (Extension) Act, which made birth notification compulsory and extended the role of health visitors. The Maternity and Child Welfare Act, passed in 1918, gave local authorities the powers to provide clinics, home visiting and either maternity homes or maternity beds in existing institutions. Under the Local Government Act of 1929, local authorities took over Poor Law institutions, including their hospitals and were given block grants to provide a range of services. Under the Midwives Act of 1936, local authorities were required to provide a salaried midwifery service, or finance voluntary organisations to do so. These increases in the

[3]see lists at end of this volume

[4]Fourth Report of Session 1990-91, Maternity Services: Preconception, HC 430-I, II and III

[5]OPCS Mortality Statistics, see figures 1-5

publicly funded provision of maternity care were accompanied by different views about how it should be given. While obstetricians and general practitioners laid competing claims for the management of childbirth, others favoured a midwifery based maternity service, particularly for normal labours and uncomplicated pregnancies. Meanwhile, the percentage of births taking place in hospitals, nursing homes and Poor Law institutions rose from around 1 per cent before the First World War to 15 per cent in 1927, 24 per cent in 1933, 25 per cent in 1937 and 54 per cent in 1946.[6]

16. The National Health Service Act of 1946 produced few direct changes in the domiciliary midwifery service and much of it remained the responsibility of the local health authorities. The NHS Act provided for the maternity services to be available for all without cost and provided for the services of both the doctor and the midwife. As part of these arrangements a specified fee was paid to the GP depending upon whether he or she was on the obstetric list. This encouraged a large number of GPs to take an interest in maternity care, reversing the previous trend to leave this work to midwives.[7]

17. In the hospital services, implementation of the NHS Act, combined with the implementation of the joint report of the Royal College of Obstetricians and Gynaecologists and the Population Investigation Committee[8] resulted in an increase in maternity beds. With reference to the joint report, the statistician Marjorie Tew (about whose work we have more to say later) says:

> "With regard to care at delivery, the Report dismissed the survey finding of much lower stillbirth and neonatal mortality rates for births at home, although these included a disproportionately large number to poor mothers in poor housing and with large families, the demographic subgroup at highest risk of a fatal outcome; instead it picked on the fact that 5 per cent of the births booked for home delivery developed complications, for which they were transferred to hospital and suffered very high mortality. Although there was no evidence that births booked for hospital delivery would not have developed the same complications or, if they had, would have suffered lower mortality, it was considered that 'until the incidence of such emergencies can be reduced, there is a good case for the encouragement of institutional delivery"[9]

The RCOG report was correct when it said:

> "if a sufficiency of maternity beds is provided in suitable institutions ... there is little doubt that in England, as in America, the institutional habit would be established for the large majority of confinements"[10]

By 1952 64 per cent of confinements took place in hospital in England and Wales; this was in excess of the declared policy of the Ministry of Health to make provision for hospital confinement for about 50 per cent.

18. In 1955/56 the Guillebaud Committee reported on "The Obstetric Service Under the NHS". It stated that:—

> "The College believes that institutional confinement provides the maximum safety for mother and child and therefore the ultimate aim should be to provide obstetric beds for all women who need or will accept institutional confinement".[11]

It also recommended that only GPs on obstetric lists should be eligible to provide the service and recommended that obstetricians, midwives and GPs should work as a team.

19. In April 1956 the Minister of Health appointed the Earl of Cranbrook to Chair the Maternity Services Committee with the following terms of reference:—

> "To review the present organisation of the maternity services in England and Wales, to consider what should be their content and to make recommendations".

The Cranbrook Report came out in 1959 and recommended an expansion of hospital maternity services and maintenance of good domiciliary maternity services and a more careful selection of patients for domiciliary hospital confinements. It also recommended sufficient maternity beds to provide for a national average of 70 per cent of all confinements to take place in hospitals. Other recommendations were that:—

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[6]Where to be Born? The debate and the evidence; Campbell and Macfarlane, NPEU, 1987
[7]MS148
[8]Maternity in Great Britain, OUP, 1946; see also MS133
[9]Safer Childbirth? A Critical History of Maternity Care, Tew, 1990
[10]Maternity in Great Britain, OUP, 1946 pp 203-4
[11]Report of the Committee of Inquiry into the cost of the National Health Service, Cmd 9663

"A midwife should be given every opportunity to participate in the maternity care of her patients to the fullest extent to which her skill and experience entitle her".

and that

"General Practitioner maternity beds [should be] situated within, or very close to consultant maternity hospitals or general hospitals with maternity departments. A consultant obstetrician should have overall responsibility for supervision of General Practitioner maternity beds".[12]

20. In September 1967 the Minister of Health appointed a sub-committee of the Midwifery Advisory Committee under the Chairmanship of Sir John Peel with the following terms of reference:—

"To consider the future of the domiciliary midwifery service and the question of bed needs for maternity patients and to make recommendations".

The Peel Committee's Report *Domiciliary Midwifery and Maternity Bed Needs* was presented to the main Committee in 1970. Amongst its recommendations were the following:—

"We considered that the resources of modern medicine should be available to all mothers and babies, and we think that sufficient facilities should be provided to allow for 100 per cent hospital delivery. The greater safety of hospital confinement for mother and child justifies this objective".

"Medical and midwifery care should be provided by Consultants, General Practitioners and Midwives working as teams".

"Small isolated obstetric units should be replaced by larger combined Consultant/General Practitioner units in general hospitals. In the latter units, all beds and facilities should be shared".

21. The 1974 reorganisation of the NHS and local government transferred community midwifery, nursing and health visiting services from local authorities to the newly formed health authorities, which were also responsible for hospital services. Despite the fact that general practitioners remained independent, the practice continued of sharing overall responsibility for care between hospitals and general practitioners, with much of the care being given by hospital and community midwives. Since 1974, hospital and community midwifery services have become increasingly integrated.

22. Public attention was again focused on the maternity services in the late 1970s, by a campaign in the media and Parliament launched in response to two Government reports. These were the report of the Committee on Child Health Services, which described Britain's perinatal mortality rates as a 'holocaust'; and the DHSS policy document 'Priorities for health and personal social services in England', which suggested that as birth rates were falling, funding for maternity care could be reduced. In response to this, the Social Services Committee set up its first enquiry into perinatal and neonatal mortality. In its report, published on 19 June 1980, the Committee stated that it had responded to:

"Mounting public concern that babies were unnecessarily dying or suffering permanent damage during the latter part of pregnancy and the earliest part of infancy".[13]

23. The report had 152 recommendations. Amongst these were:—

"An increasing number of patients should be delivered in large units; selection of patients should be improved for smaller consultant units and isolated GP units; home deliveries should be phased out further".

"We consider that the safety of the mother and baby in labour are of paramount importance and recommend that the labour ward should be regarded as an intensive care area and that staffing and equipment be optimal".

"Patient care throughout the National Health Service should be given by fully trained doctors in career posts, and that a significant amount of work at present done by junior doctors should be transferred to consultants".

"It should be mandatory that all pregnant women should be seen at least twice by a consultant obstetrician—preferably as soon as possible after the first visit to the GP in early pregnancy and again in late pregnancy".

[12]ibid
[13]ibid, p. 1

"In future the hospital and GP obstetric services should be unified by the creation of a single body called a 'Maternity Services Committee'. An obstetrician, a paediatrician, a GP on the obstetric list and a midwife will be members".

"Steps should be taken to make better use of the skills of the midwife in maternity care - particularly in the antenatal clinic and labour ward where they should be given greater responsibility for antenatal care of women with uncomplicated pregnancies".

"We recognise the difficulty of providing continuity of care throughout pregnancy and labour, but consider a measure of it can be attained by reducing the numbers of mothers attending clinics and by encouraging midwives to take part in providing antenatal care. In the labour room continuity can be improved by appointing doctors solely to duty there throughout the 24 hours and by increasing the midwifery staff so that the ratio of one midwife to one mother is achieved".[14]

24. In accordance with the recommendations of the Social Services Committee the Government set up the Maternity Services Advisory Committee which produced three reports:- "Maternity Care in Action", "Antenatal Care and Intrapartum Care" and "Postnatal and Neonatal Care".

One of its recommendations was:—

"To promote the recognition and use of the GPs' and midwives' skills and those of other members of the primary health care team, enabling them to provide mothers whose pregnancies are regarded as 'low risk' with more of the antenatal care in the community, reducing both the inconvenience of travelling for the mother and the load on the hospital service".

and

"To ensure that the best possible standard of maternity care is available for all mothers".

Picking up on the proposals relating to safety, in the chapter of 'Maternity Care in Action' entitled 'Planned Home Births' the following policy statement was propounded:

"As unforeseen complications can occur in any birth, every mother should be encouraged to have her baby in a maternity unit where emergency facilities are available"[15]

25. This emphatic conviction that birth in a consultant obstetric unit provided the surest guarantee of a healthy baby has led to the current situation where 98 per cent of women in this country now give birth in NHS hospitals, of which about 4 per cent in 1989 were in GP units and the rest in consultant obstetric units.[16] Assessments of the benefits of this development differ. Perhaps the most radical view is presented by Mrs Marjorie Tew, to whom we have earlier referred, a medical statistician and author of *Safer Childbirth? A Critical History of Maternity Care*[17] whose analysis of the statistics relating to the safety of different places of birth provides what she herself describes as 'revolutionary conclusions'.[18] She says:

"First of all there is the obvious evidence that since 1950 mortality rates have gone down a lot. At the same time hospitalisation rates have gone up and everybody fell into the trap of making a causal connection between these two serial time trends. When you carry out the first statistical test to see whether there is likely to be a causal connection, you find that the causal connection, if any, is in the opposite direction. We found that the years when hospitalisation increased most were the years when perinatal mortality declined least. There is a strong negative correlation between these figures".

In her analysis which she provided to the Committee in a written memorandum she alleges that the policy of directing all confinements into hospitals was driven more by the territorial imperatives of the RCOG than by a disinterested analysis of the evidence.[19] While her views provoke strong reactions, they are not dismissed as without foundation. Professor Eva Alberman, an epidemiologist and Adviser to the Social Services Committee in 1979-80 and subsequently, said of her work

[14]ibid, pp 158-173
[15]Maternity Care in Action, HMSO, 198
[16]see figure 6
[17]Chapman and Hall, London, 1990
[18]Q1388
[19]MS133

"She has really made us think very hard, about assumptions that I had made pretty readily"

and when pressed to give a view on whether Mrs Tew's work proved conclusively that consultant unit or other births were safer, she declined to come down on either side.[20]

26. Other witnesses take a stronger view than Professor Alberman, though few follow Marjorie Tew so far as to assert that the negative correlation between year to year decreases in the PNM rates and increases in the level of hospitalisation implies that hospital birth is more dangerous than home birth. The most recent and convincing work in this area, and work which has, as far as we are aware, not been substantially challenged, is that by Rona Campbell of Queen's University, Belfast and Alison Macfarlane of the National Perinatal Epidemiology Unit at Oxford.[21] While they said of Mrs Tew's work that they were 'not convinced that she has taken adequate account of the selection factors involved when drawing her conclusions',[22] in the memorandum which they submitted to the Committee summarising their work, they remark that:

> "The statistical association between the increase in the proportion of hospital deliveries and the fall in the crude perinatal mortality rate seems unlikely to be explained by a cause and effect relation"

and, most importantly, they state unequivocally that:

> "There is no evidence to support the claim that the safest policy is for all women to give birth in hospital, or the policy of closing small obstetric units on grounds of safety".[23]

27. These views were endorsed by the Royal College of Midwives (RCM),[24] by the Association of Radical Midwives, by the Maternity Alliance,[25] by the National Childbirth Trust,[26]by the Association for Community-Based Maternity Care,[27] and by the Association for Improvements in Maternity Services,[28] among many others from whom we heard both formal and informal evidence.

In an editorial in the Lancet in 1986 it was acknowledged that "in the light of the accumulated British evidence, neither the lack of safety of birth at home nor the greater safety of birth in hospital had been proved, a judgement contrary to established medical claims". In support of this view, Dr Wendy Savage, a consultant obstetrician at the Royal London Hospital, wrote in evidence to the Committee that

> "the move of the place of birth from home and GP Maternity Unit to hospital in the UK has not been based on good scientific evidence. It has been accompanied by an increase in intervention and a fall in the perinatal mortality rate. Whilst intervention appears to be a consequence of birth in a hospital environment, which is geared towards expected abnormality, the reasons for the fall in perinatal mortality are more complex. Improvements in diet, housing, education and preventive health services, the ability to plan a family using contraception and abortion where necessary, and the consequent reduction in the proportion of older women and those of high parity have all contributed".

We also asked witnesses from the British Association of Perinatal Medicine and the British Paediatric Association about the safety of home birth. Professor Hull (BPA) said:

> "... it was a misunderstanding of the original statistics of the 1958 study that led to babies all being delivered in hospitals. The data was there and was not scrutinised clearly enough. I think one has to look at it carefully but my view would be that babies can be safely delivered at home".[29]

Professors Cooke and Levene of the BAPM both agreed with him.[30]

28. The position was disputed by a number of witnesses who maintain that hospitals are the safest place to give birth. At its most unsophisticated this was attempted by the officials from the Department of Health who simply presented the statistics for PNM rates and the level of hospital deliveries in 1955 and 1989.[31] They made no attempt to justify this crude and now thoroughly

[20]QQ1373-1374
[21]MS243
[22]MS243, 3.10
[23]see figure 7
[24]Ev p 122, para 3.4; Q440-445
[25]Ev p 89, para 1.3
[26]Ev p 252
[27]Q1406
[28]Q1191-1211
[29]Q1101
[30]Q1101
[31]Q623-4

discredited approach to the evidence, but Dr Walford went on to maintain, without new evidence, that 'the safest place, as far as we [the Government] can ascertain, to have a baby is in hospital with full facilities'.[32] Dr Walford also stated that the Department had 'no indication that that advice, were we to seek it again, from the professional bodies would be different.'[33] The Department clearly has not heard the views of midwives and epidemiologists on this subject. Nor have they taken account of the statement of Mr Duncan Nichol, Chairman of the NHS Management Executive, to the Public Accounts Committee, that 'there is no statistical evidence to show whether GP Maternity Units are less safe than those in District General Hospitals.'[34] The RCOG gives some support for Dr Walford's belief in that they have said "... labour remains a potentially dangerous time and delivery in hospital is the only safe option".[35]However they have also said "... there is no conclusive evidence that hospital delivery is safer than home ..."[36]

29. In the course of a prolonged series of exchanges between the Minister for Health and her officials and the Committee on this subject,[37] the Department stuck to its position that women should be encouraged to give birth in hospital for reasons of safety. This position was reiterated as recently as 22 November 1991 in an answer to a parliamentary question which stated

> "the Department's policy remains that, as unforeseen circumstances can occur in any birth, every mother should be *encouraged*[38] to have her baby in a maternity unit where emergency facilities are readily available".[39]

However, when the Minister of Health returned to give evidence to the Committee at the final session of this inquiry on 16 January, we detected a shift of emphasis. She acknowledged, without reservation, that there was no reliable statistical evidence which established the superior safety of birth in consultant obstetric units as against home births and those in GP units,[40] stating that

> "there is no overwhelming ... unequivocal evidence, about the relative merits of different settings [for delivery] and some of the evidence is conflicting ..."[41]

30. Despite this change of emphasis, the Minister continued that although:

> "there is no clear, overwhelming evidence on that front, ... that has to lie alongside commonsense and, indeed, professional judgements about what is the safest way for a woman to give birth".[42]

We suspect that this view holds less hegemony in professional judgements than the Minister suggests. While Mr Stanley Simmons, President of the RCOG, had expressed his view to the Committee in earlier oral evidence that:

> "I suspect we are being much too cavalier about this idea that people will give up safety because of the other benefits..."[43]

Professor Eva Alberman, in contrast, remarked that

> "We are very hung up on mortality as an outcome ... If we really were not to use mortality but to use satisfaction as an outcome, the answers might be very different".[44]

31. We also suspect, after listening to all the evidence that we have heard in this inquiry, that the appeal to 'commonsense' is in fact a disingenuous disguise for an appeal to prejudice. When asked about the closure of GP units, Dr Young of the Association for Community-Based Maternity Care said:

> "I should say that in part that is due to the decisions of previous Committees which have been advised, perhaps over heavily, by a hospital based specialist and have been led to the opinion that birth outside large hospitals was very dangerous .. there is certainly not evidence there and it is very unfortunate that so many small hospitals were closed on such amazingly

[32]Q626
[33]Q630
[34]Thirty-fifth Report from the Committee of Public Accounts, Session 1989-90, HC 380, p.20
[35]Ev p. 146 9.2.3
[36]Ev p. 145 9.1
[37]QQ812-833
[38]our emphasis
[39]Official Report, 22 Nov 1991, written answers 330w
[40]QQ 1515-1519
[41]Q1519
[42]Q1518
[43]Q500
[44]Q1394

scant evidence. Unfortunately the Department of Health, so far as I can see, will still not take a stand and say that perhaps this needs protecting".[45]

32. While the report of the Social Services Committee in 1980 still stands as a landmark in the battle to reduce unnecessary deaths among babies, this inquiry has led us to acknowledge that it has been used, too often, as an excuse for pushing the delivery of maternity care in a direction which goes against the grain of many women's wishes. The views that prevailed more than a decade ago now need objective reassessment. We believe that the debate about place of birth, and the triumph of the hospital-centred argument, have led to the imposition of a whole philosophy of maternity care which has tended to regard all pregnancies as potential disasters, and to impose a medical model for their management which has had adverse consequences in the whole way in which we think about maternity care.

33. Strong views are held on the question of place of birth, and as we have seen, the issue of safety has been used as the primary driving force behind the development of the pattern of normal maternity care for low-risk as well as for high-risk women. We discuss some of the concerns about the perceived risks of birth outside acute hospitals in chapter III in more detail. However, it is now widely acknowledged that these strong views are not all equally supported by evidence. **On the basis of what we have heard, this Committee must draw the conclusion that the policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety.** There is no convincing and compelling evidence that hospitals give a better guarantee of the safety of the majority of mothers and babies. It is possible, but not proven, that the contrary may be the case.[46] **Given the absence of conclusive evidence, it is no longer acceptable that the pattern of maternity care provision should be driven by presumptions about the applicability of a medical model of care based on unproven assertions.**

34. In the next two chapters we therefore turn to consider the evidence we have received from women who use the maternity services and the professionals who provide them. In doing so, we will take as our guiding principle the philosophy which was best expressed by the Association for Community Based Maternity Care in their written evidence, that

> "Discussions concerning maternity care have been distorted in the past by attention paid to opinion and not to scientific evidence. Unfortunately, evidence on many issues is lacking. Where this is so we believe extra attention should be paid to women's wishes ... As professionals we do not believe we should dictate the pattern where science cannot support such a pattern".[47]

They also told us that they believed that the application of different criteria of success does not necessarily favour one professional group over another.[48] We concur, and in examining which standards are to be applied we make no presumption that one professional group has a greater claim to control over the maternity services than any others. That control should lie in the hands of mothers and mothers-to-be.

CHAPTER II: WHAT WOMEN WANT

Introduction

35. Our key measure of the success of the maternity services in terms of their effectiveness and appropriateness will therefore be the response from those who use them. The way women respond to and express satisfaction with their experience of using the maternity services is largely dependent on the extent to which they consider their needs are met sufficiently during the process. We therefore sought to establish what desires women express in terms of a responsive and appropriate maternity service, and to compare this with what they actually experience.

36. Evidence from organisations representing users of the service included both written and oral evidence from the National Childbirth Trust (NCT), the Maternity Alliance, the Association for the Improvement in Maternity Services (AIMS), the Stillbirth and Neonatal Death Society (SANDS) and Support After Termination for Abnormality (SATFA). We received written evidence from the Miscarriage Alliance and the Twins and Multiple Births Association (TAMBA) and written evidence on specific interventions during childbirth from researchers. We also received written and oral evidence from individual women who had given birth.

[45] Q1406
[46] MS243
[47] MS47
[48] MS47

37. Inevitably there is an element of self selection in these groups and this may lead to suspicions of some bias in their evidence. However, the Committee's examination of that evidence would suggest that there are some themes so common that they should be interpreted as representing a much more widespread view than it is possible to obtain at first hand. In addition, on our several visits to varied areas we made a point of having informal discussions with women, and found that they echoed the themes and points being put by the organisations. This reinforces our belief that the formal evidence is representative of the wishes of women.

38. Likewise, an analysis of the evidence from individual women reveals three strong common elements:

— The need for continuity of care.

— The desire for choice of care and place of delivery.

— The right to control over their own bodies at all stages of pregnancy and birth.

We begin by examining these broad themes.

Continuity, Choice and Control

Continuity of care

39. Mrs Betty Binysh, a mother of two (one born in hospital and one at home) stated:

> "Continuity should mean the mother knows the midwife who will do the delivery. For both the hospital and home birth I saw one midwife for all antenatal check-ups, but she did not do the delivery. This is a form of continuity but it is not very useful.
>
> A stranger meets you when you are under pressure in labour. You need to have the chance to become relaxed with and build up confidence in your birth attendant when you are not under pressure. It would be far better to see several midwives for antenatal care, one of whom would do the delivery".[49]

40. Mrs Shakespeare, writing as a mother and an NCT breastfeeding counsellor, summarised her own and other women's needs:

> "1. Continuity of care through pregnancy, birth and the postnatal period is of primary importance to mothers.
>
> 2. Large maternity units are seen as impersonal and even hostile to mothers.
>
> 3. Mothers would like more choice in the important matters of place of birth and types of care offered.
>
> 4. Midwives are the most important medical personnel in the management and care of normal pregnancy and birth. In view of the points, may I ask that GP units and domino schemes be given special consideration and that mothers are made aware of these options, and of the option of home confinement".[50]

41. Evidence from all the users groups reiterated these themes. The NCT in its written evidence stated:

> "During the antenatal period women feel devalued and demoralised if they see a succession of different personnel who know nothing about their history and, because of lack of continuity, are inclined to give different prognoses and contradictory advice".

and

> "Women are particularly concerned about who will be with them during labour, a time when they are at their most powerless because they cannot get up and walk away if they are unhappy with what is offered. The care and attendance of a known individual at this time is of itself supportive, provided that individual is felt to have the necessary approach and skills to provide optimum assistance".[51]

42. The Maternity Alliance recommended that:

> "There should be a clear recognition of the social importance of a community setting for antenatal care which will sow the seeds of the postnatal support which is vital to the needs of mother and baby. Antenatal care should be regarded as one phase within a continuous web of

[49] MS28
[50] MS78
[51] Ev pp 232-3

care which is provided, as far as possible, by the same small group of professionals and within the woman's own community".

and that

"The professional management of birth should be undertaken by an experienced midwife working in a small team in order to offer continuity of care throughout pregnancy, birth and postpartum".[52]

43. AIMS drew attention to the Know Your Midwife Scheme, to Effective Care in Childbirth and Pregnancy (Enkin & Chalmers) and to a survey in Lothian Maternity Services which all stressed the importance women place upon continuity of carer. We also received evidence about the special and pressing needs of particular groups of women. For example, continuity of care is particularly important for women with special problems such as social isolation, homelessness and disability; or those who are travellers and the very young.[53]

44. The Committee visited two health authorities where a reorganisation of midwifery services has enabled women to receive care from a small team of midwives (in both cases about 6 or 7 strong), Riverside Health Authority (Bessborough Street Clinic), and Mid Glamorgan Health Authority (the Rhondda Know Your Midwife scheme). At both we were able to elicit the views of women who were having their maternity care in the new schemes.

45. At the Bessborough Street Clinic, mothers who met the Committee at the clinic identified a range of advantages to the community midwifery teams, such as; care was felt to be more focused on the needs of the woman as a person and not just as a carrier of her baby; more time is given than in hospital or by the GP to explaining things in detail and to answering questions; a woman has more choice over where to give birth; the woman in labour should never be confronted by a room full of strangers.[54]

46. Similar very positive views were expressed by the women who received their care through the Rhondda scheme. For example, one of the mothers who had recently given birth within the team midwifery scheme read to us a letter in which she stated:

"... it is without a doubt that the professionalism, continuity and familiarity and, I hope, friendship of the Domino Team which gave me the confidence to enjoy a relaxed pregnancy and a memorable birth ... ideally this facility should be available to every woman in Britain".[55]

This enthusiasm was echoed in the evidence of all the mothers we heard from on this visit, without exception.

47. That women value the care they receive from midwives and would like to see a greater emphasis on continuity in this aspect of their care was, like the views expressed in individual letters, also stressed by the consumer groups. The NCT drew attention to the

"important distinction between those whose expertise is the supervision of health and the detection of disease and those whose speciality is the management of disease and the restoration of health".[56]

They then recommended that

"A change of central government policy is needed to reinforce the establishment of midwives as the routine primary care giver for all women at low risk, regardless of place of birth".[57]

48. The Maternity Alliance stated that:

"... the great majority of births, which are obstetrically straightforward, would be best supervised by midwives organised so as to provide maximum continuity of care and carer. As midwives are the experts in all stages of normal childbirth, this would be safer for women and babies, more rewarding for staff and the women giving birth and, probably more cost effective for the health service".[58]

49. AIMS, echoing Marjorie Tew's views on the role of obstetricians to which we have earlier referred, stated that:

[52]Ev pp 88-89
[53]MS98, Ev pp 93-94
[54]MS238
[55]MS398 Add 14
[56]Ev p 232
[57]ibid
[58]Ev p 89

"Most deliveries in this country are conducted by midwives. Yet maternity care policies have been dominated by obstetricians. Since midwives have had to work on hospital premises under the control of the health authority, they have become more like nurses—accepting doctors' orders rather than being professionals in their own right. They have had to follow clinical policies laid down by the medical staff, even when they felt this was not in the interest of the woman they were caring for".

and that

"Expensively trained midwives are being used for trivial work in hospitals, the community and GP practices. Many of them no longer deliver babies. In our view a midwife who does not do deliveries is not a midwife".[59]

We conclude that there is a strong desire among women for the provision of continuity of care and carer throughout pregnancy and childbirth, and that the majority of them regard midwives as the group best placed and equipped to provide this. Clearly this will not happen without special planning, and later in this report we consider ways in which it might be brought about.

Choice of treatment and place of delivery

50. The Committee received much evidence in support of the case for providing more choice for women in their maternity care. In relation to the general care they receive they ask for sufficient opportunity to make informed choices, to be treated as equal partners in their care and to have a real range of facilities from which to choose - both choice of personnel giving care and where care would be given. Maternity Alliance, making reference to principles in the NHS reforms, states:

"In keeping with the Government's stated commitments to increasing patient choice, every pregnant woman should have the opportunity to receive care in the community or the hospital of her choice, from the health professionals of her choice, and for as long as she feels necessary".[60]

51. The Department of Health Memorandum on delivery states:

"Women should as far as practicable, be able to choose and have access to the type of care which they feel is best suited to their needs".

However, the Committee received evidence both from women and the organisations that represent them that the choices available are often more illusory than real. Even the most articulate and assertive women may have difficulty achieving maximum choice in their contact with the maternity services. Women who, for various reasons, experience further inequalities on account of their race, culture, socio-economic status and age, will have even more difficulties.

52. At a national level, several of the consumer groups emphasised the absence of real choice which resulted from institutional factors, principally the drive towards 100 per cent consultant unit deliveries. More particularly, individual witnesses tended to focus on the difficulties of overcoming the reluctance of the professionals involved to facilitate free choice. There was a strong theme of evidence which drew on experiences of obstruction and deliberate delay. A father summed this up in the last comment given in oral evidence to this inquiry:

"My vivid memories of especially the first birth are fighting administration when it should have been just getting into family life and being prepared to have a new member of the family. A lot of our time went into debates with midwives and again doctors, passing us on basically".[61]

We conclude that there is a widespread demand among women for greater choice in the type of maternity care they receive, and that the present structure of the maternity services frustrates, rather than facilitates, those who wish to exercise this choice.

Control and participation in care

53. Another common factor running throughout the evidence was that women want to feel in control of themselves and what happens to them during their pregnancy, delivery and after giving birth. Evidence suggests that women are more satisfied with the service if they feel in control and perceive themselves as participants in their care rather than passive recipients.

[59]MS277 ps 3.2 and 3.3
[60]Ev p 81
[61]Q1585

54. Sheila Kitzinger, who has written and researched extensively on women's experience of birth, in her evidence said:

> "Women who feel that they can retain control over what is happening to them during the birth, who understand the options available and are consulted about what they prefer, are much more likely to experience birth as satisfying than those who are merely at the receiving end of care, however kindly that care".[62]

and

> "Life events may be endured as processes over which one has no control, or perceived as experiences in which one is a decision-maker and active participant.
>
> Important elements in a good relationship with care-givers are that a woman has all the information she seeks, knows her wishes will be respected and is treated with consideration and kindness. When all these factors are present even a difficult labour and a complicated birth can be a positive experience".[63]

One of the women who had recently given birth who gave evidence to the Committee described the importance to her of being in control and how this can be affected by the environment in which care is given:

> "... even when you are getting excellent care and very sensitive midwifery it is still, when you are on somebody else's patch, very difficult to stick out for what your whole body is telling you".[64]

55. By looking at the antenatal, intrapartum and postnatal stages of the maternity services, we examined in more detail the ways in which these issues were highlighted by women using the services and considered the evidence which suggests that existing services fall short of women's expressed needs.

Antenatal Care

Introduction

56. Currently, antenatal care is performed mainly by three groups of professionals: midwives, general practitioners and hospital doctors. The type of antenatal care that is selected for an individual patient depends on local arrangements. By far the most common format of care is shared care between general practitioners and hospital clinics. There are however in some areas patterns of total midwife care in the community or shared care between the midwife and the hospital. Occasionally, antenatal care is given at home.

57. We have received much evidence that antenatal clinics too often fail to satisfy women's needs for continuity of care, choice and control in the management of their care. The NCT in its written evidence stated, that from members' comments

> "A very clear picture has emerged of lack of time at antenatal clinics, failure to explain reasons for procedures and failure to offer information clearly ... many commented that their antenatal care was conducted in an impolite, inconsiderate and off-hand way ...
>
> Antenatal visits often involve long and expensive journeys, sometimes with young children in tow".[65]

58. This evidence is borne out in surveys undertaken by Community Health Councils:

> "Travelling costs, times and child care facilities all need to be borne in mind by the service providers at the planning stage if women are not to be discouraged from attending".[66]

59. AIMS points out the length of time women have to wait and the numbers of different people seen at clinics.[67] Similarly, TAMBA noted the particular problems for women carrying two or more babies that are engendered by long waiting times in clinics.[68]

60. Giving evidence to the Committee, Ms Gartland, one of the mothers we heard from who had chosen a home birth, highlighted the contrast between receiving antenatal care in a hospital clinic and receiving it at home: the antenatal clinic was "grim; there were so many women there were not

[62]MS1
[63]MS1B
[64]Q1571
[65]Ev. p. 240
[66]MS399
[67]MS119 2.3
[68]MS52 4.8

enough chairs for everyone to sit down",[69] whereas having eventually managed to find out that she could go ahead with a home birth, "... the midwife came to my home and we had my checks in my flat, in my lounge, and I would lie on the sofa for her to examine my stomach..."[70]

61. A small general practice in Newcastle under Lyme has attempted to address the shortcomings they perceived in antenatal clinics.[71] They described the clinics as insensitive to patient needs (not dealing sufficiently with many women who seem prone to back problems during pregnancy), placing too much emphasis on measurement, providing no opportunity for education or a wider range of "alternative" therapies and providing inflexible care that takes no account of when women would find it convenient to attend.

Information Provision

62. One of the clear messages that has come from 'consumers' in this inquiry is that unless women are given sufficient, balanced, non-judgemental and appropriate information at each stage of the maternity process they are unlikely to feel able to make informed choices about their care. This is particularly important during the antenatal period when women have time to digest and prepare themselves for the various options that they may later face. However, evidence received by the Committee suggests that many women do not have access to as much information as they feel they need.[72] This includes the right to change GP in order to find care appropriate to their needs,[73] information on multiple births[74] or information about local voluntary organisations and self-help groups.[75]

63. AIMS in written evidence states:

> "A crucial choice is made for the woman when the GP decides which consultant to refer her to. Rarely is the woman informed about her right to choose the obstetrician herself. Yet policies of different obstetricians within the same hospital, and their intervention rates, vary widely"

and

> "In order to make effective choices, women need basic information, and sometimes this is not even available to CHCs".[76]

64. Ms Gartland told the Committee that the doctor she saw at the booking-in clinic in King's College Hospital had never heard of a domino delivery.[77] Similarly Ms Unwin explained that although it may be possible to change doctors in order to be able to have a home birth and that the Family Health Services Authority can provide you with a list of local doctors, "Nobody tells you that, nobody gives you information".[78]

65. The NCT cites as one of its major concerns regarding antenatal care "the lack of provision for women to make informed choices about their antenatal care".[79] Ms Nash expressed the extent to which a lack of information or the provision of biased information has undermined women's confidence in their own choices:

> "... true choice is not available when you first go to your antenatal clinic because you get a very one-sided view about risk ... and it will be a long time before women can somehow re-educate themselves to trust their instincts".[80]

66. AIMS[81] commented on the quality of advice and information given at some Health Authority antenatal classes:

> "These do not encourage parents to take responsibility for their pregnancy and health but seem designed to ensure they accept the care that is available in the hospital. In some areas women are actively dissuaded from seeking information from other sources or attending

[69]Q1565
[70]Q1566
[71]MS407
[72]MS119 2.3, 2.4, Ev p 240
[73]Ev p 242
[74]MS52 4.1
[75]Ev p 234
[76]MS277 6.7 and 6.8
[77]Q1566
[78]Q1584
[79]Ev p 239
[80]Q1570
[81]MS119 2.4

independent classes. Very little information about user groups is available in NHS classes or clinics".

67. The Association of Community Health Councils for England & Wales (ACHCEW)'s report on antenatal services highlights women's experience in this area:

> "Now I realise I was given hardly any information in the way of leaflets and booklets. Any information I got was through having to ask".[82]

68. Another type of information which women have expressed a need to have is their own medical notes or a copy of them; women do have the legal right to hold a copy of their own notes. However, the Royal College of Midwives stated,

> "We have had considerable difficulty in facilitating women having a true choice over whether they wish to carry their own notes or not ... There are very few pregnant women who have assertiveness skills sufficient to take on arguing with the medical staff. They often feel that their pregnancy care may be jeopardised in some way if they appear difficult".[83]

This view was borne out by Ms Nash, another mother whom we invited to give evidence to us, when she stated that,

> "... if I was not somebody who was worried underneath about authority and what it does to you when you stick your neck out too far ..."

perhaps she would have insisted that she had her notes, but as it was she did not.[84] Schemes in which women keep and carry their own notes have been successfully introduced by several hospitals, thus helping to overcome some of the discontinuities created by shared care. In all these cases it appears that the rate of loss of notes is lower than when the hospitals retained them.

69. We heard how the problem of obtaining information was exacerbated when women came from ethnic groups where English was not their first language. Linkworker and advocacy schemes have proved valuable in making the health and social services more accessible and acceptable to people from minority ethnic backgrounds. For example, in the three years that one Turkish speaking linkworker had been in her post in a GP's surgery in London, contraception take-up increased from 3 per cent to 75 per cent, termination of pregnancy requests decreased from 25 per cent to 1 per cent, all the children are fully immunised, and the smear cover is presently at 67 per cent of target, for the Turkish speaking patients.[85] However, the Department of Health does not know how many linkworkers there are and where they work,[86] thus suggesting that progress in this area is not being closely monitored. **We recommend that information about linkworkers be obtained and evaluated.**

70. It is clear to us that women need to know why a particular antenatal screening procedure might be necessary, what the procedure involves and any potential dangers or drawbacks before deciding whether or not they need or want to undergo that procedure. However, written evidence from AIMS states

> "we are very concerned about the lack of information that women are given about the possible risks and benefits of any proposed tests and treatments".[87]

Whilst recognising that many of the technologies developed for use in antenatal screening have value, Ms Beech stressed it was the routine use of technology that AIMS was questioning.[88]

71. Organisations representing users of the service also pointed out the need for sensitivity in imparting the results of screening procedures to pregnant women and the need for counselling where appropriate. For example, TAMBA states

> ".. it is important that scanographers understand the implications to the parents of the news of their multiple pregnancy. Training should be given to enable them to impart this news in a sensitive and caring way".[89]

72. Ms Dimavicius of SATFA reiterated this point in relation to women being told following routine ultrasound that their baby has some fetal abnormality:

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[82] MS427A
[83] MS419
[84] Q1572
[85] Ev p 87
[86] MS383
[87] MS119 2.6
[88] Q1210
[89] MS52 4.11

"Quite often, again, I can think of several parents who have just driven home in floods of tears and they have actually risked their own life and the lives of others because arrangements have not been made for them to be escorted home".[90]

73. **We conclude that many women at present feel that they are denied access to information in the antenatal period which would enable them to make truly informed choices about their care, their carer and their place of birth. They are unnecessarily deprived of access to their medical notes. Too often bad news is given in an unsympathetic way. Too often they experience an unwillingness on the part of professionals to treat them as equal partners in making decisions about the birth of their child.**

Intrapartum Care

Place of delivery

74. The issue of choice was most starkly highlighted by the debate over the place of birth. We have at the beginning of this section referred to the considerable evidence on this that came from individual women, and in the first chapter discussed the debate on this issue at national level. The Department of Health informed us that:

"It may be possible for a woman and her partner to choose between birth in a consultant maternity unit, in a GP maternity unit, under a "domino system" or at home, depending on the facilities available in the area".[91]

(The acronym Domino is derived from DOMiciliary-IN-Out, and should imply domiciliary antenatal care by a known midwife who comes to the woman's home to assess her in labour and delivers the baby in hospital, and then accompanies the mother and baby home after early discharge).

75. The reasons women give for wanting a domino, or home birth are varied and demonstrate the importance of providing a choice which caters for the needs of the individual. Ms Hutton of the NCT stated in her oral evidence,

"For one woman it is about avoiding technology certainly but for another woman she is not even thinking about the technology; she is thinking about being in her own community".[92]

Ms Newburn from the NCT emphasised the freedom from accepted but not scientifically evaluated medical practices that births outside a hospital environment can give:

"I think it is very obvious that one of the reasons why a woman chooses a home birth is that there are far fewer pre-conceived ideas about what is normal".[93]

Sheila Kitzinger in her recent book[94] lists a number of other reasons why women prefer to choose a home birth, including the ability to labour without interventions or drugs and that the woman is never separated from her baby in the majority of cases where labour does not go wrong.

76. However the statistics on actual place of birth, provided by the Department, would suggest that such choice of facility is very limited with only six per cent delivered in other than a ward with consultant supervision available.[95] We do not find this surprising for, although the Department has stressed the importance of choice for women, as we have seen they also advise professionals, in the MSAC's second report on intrapartum care, that every woman should be encouraged to have her baby "in a maternity unit which can offer a range of obstetric, paediatric and supporting services necessary to cope with an emergency".[96] To follow government guidelines therefore, all professionals who are in a position to assist the woman to making an informed choice must bias their advice in favour of the equipped maternity unit. We have had considerable evidence that women who wish to have home a birth not infrequently find themselves in a confrontational situation with the team of professionals who are available to give them care.

"For my second child the midwife used the booking 'interview' to fill in her form and tell me the type of care I would get - a domino delivery in Basingstoke hospital. I had to refuse and insist I wanted a home birth. She reluctantly said "they would consider it". It was only because I had read books following my first labour, that I knew I had a choice and could insist".[97]

[90]Q1293
[91]Ev pp 181-182
[92]Q761
[93]Q763
[94]Homebirth and Other Alternatives to Hospital, Dorling Kindersley, 1991
[95]Ev p 187
[96]Ev p 182
[97]MS28

77. We do not suggest that it is only the inconsistent approach by the Department that causes this situation as it is clear from evidence that other factors also play a part. Most GPs and even many midwives have lost confidence in managing intrapartum care away from a consultant unit and several witnesses expressed the view that training for GPs focuses so strongly upon the management of abnormal situations that many now do not have the requisite skills in the first place. Dr Waine of the RCGP expressed the view that medical students "are almost educated out of participation in intranatal care",[98] a phenomenon for which he laid the blame on the RCOG.[99] Dr Peter Kielty sent us a copy of his lecture to the Royal Society of Medicine in which he makes a similar point, saying:

> "Our GP trainees have been reared in their SHO [obstetric] training posts on a diet of abnormality and fear, sufficient to discourage them for life. New doctors today never were steeped in blood and liquor as students in the way that we older ones were, and they really do believe that *all* maternity care is abnormal".[100]

78. There is also significant evidence of women being denied a home birth for no apparent medical reason. In a letter to Mr David Hinchliffe MP, Ms Ruth Unwin described how her GP told her the practice could not offer her a home birth because none of the doctors felt they had the necessary expertise to provide cover and that she would have to go outside the district to approach another doctor for antenatal care (this was not a practical option for her).[101] She concluded,

> "... it is important that hospitals are there for those who want or need the reassurance they offer but I feel very strongly that home births should be treated as a viable option".[102]

79. The Maternity Alliance in its oral evidence illustrated the depth of this particular problem:

> "Hardly a week goes by at Maternity Alliance without somebody phoning to say they would like a home confinement and they are being obstructed ... Usually these women have said they have not been given any medical reason why they should not have it, but they have had all sorts of threats held over them, they have been made to sign forms that absolve the GP or midwife from any responsibility if anything goes wrong. They are fairly desperate panicked women".[103]

80. Women giving evidence to the Committee illustrated the limited choice offered to women about where they can give birth. Ms Gartland said her doctor asked her where she wanted to have her baby but that this implicitly meant which hospital.[104] Similarly, Ms Unwin said,

> "You go and they say, "Where do you want to have a baby?" and they mean in which hospital; they do not mean, do you want to have it at home or in a swimming pool or wherever - it is not a choice really".[105]

81. In her oral evidence Ms Beech of AIMS summed up the lack of control that women feel in relation to where they give birth:

> "Essentially what we have had is 30 years of women's confidence in their ability to give birth undermined by obstetric care, by the attitude that it is a very risky business and the only way that you can protect yourself from risk is to come to hospital".[106]

82. Contrary to what some professionals may think, if women choose a home birth they are not deliberately flouting evidence of risk:

> "The decision you make is clearly based on what you think is best for your child".[107]

Mrs Jean Robinson of AIMS made the same point that,

> "Women's criteria for risk and what is risk and morbidity are not the same as the criteria which obstetricians are using".[108]

83. Throughout our investigations we also heard of the steady rate of closure of small, usually GP-led, maternity units. In a letter from the Senior Principal Medical Officer, Department of

[98] Q662
[99] Q677
[100] MS148
[101] MS377
[102] ibid
[103] Q341
[104] Q1565
[105] Q1573
[106] Q1207
[107] Q1567
[108] Q1201

Health to the Chairman of the General Medical Services Committee of the BMA, it was stated that "small and isolated units *could* be proposed for closure even if not under-used, because they lack the staff and facilities to provide for emergencies".[109]

84. It did not require an inquiry by this Committee to highlight the debate engendered in many places by proposals to close small maternity units. While our inquiry was in progress we received many letters expressing opposition to the proposed closure of the Andover Maternity Unit in Hampshire. Whenever one of these units has come under threat, the often almost universal opposition of local communities has frequently been overridden on arguments of safety or cost, although we have not been offered evidence establishing the validity of such justifications.

85. The Committee was invited by Dr Richard Porter, a consultant obstetrician and manager of the maternity services for Bath Health Authority, to visit his authority which is believed to have the largest proportion of births in such units anywhere in England. It was clear to us from our discussions with mothers and their families that the option of birth in such units was one that was highly valued by the women who had chosen them. We were, ourselves, very impressed by the quality of care given by the units at Devizes, Trowbridge and Chippenham which we visited in terms of environment, accessibility and the level of professional support given. Equally striking was the evidence of the commitment of the midwives working in these units to the style of care provided: several had come in on their day off expressly to talk to the Committee about their new found enthusiasm for work which had been instilled by the creation of an integrated midwifery service which enabled them to provide care for mothers antenatally, intrapartum and postnatally. Bath CHC wrote to us to express strong support for the system operating in their area. They told us that, "This support is based on the clearly expressed preference of mothers for the continuation of GP maternity services".[110]

86. **We conclude that the choices of a home birth or birth in small maternity units are options which have substantially been withdrawn from the majority of women in this country. For most women there is no choice. This does not appear to be in accordance with their wishes.**

Interventions

87. What women seem overwhelmingly to want in relation to intervention during labour is information on possible risks and benefits so that they can make an informed choice about what they feel is best for them. Though the range of possible intervention is large, their attention was focused on the common ones such as induction, caesarian section, episiotomies and pain-relief. This information needs to be forthcoming during antenatal care so that decisions are not necessitated without time to absorb their implications. In its written memoranda the Department of Health stated,

> "It is generally accepted that interventions in childbirth should be avoided unless there are clear medical indications to the contrary".[111]

88. This assumes that there is good information about relative risks and benefits of different interventions and forms of care, and that this information is acted upon. However, the National Perinatal Epidemiology Unit has made the point that:

> "... the routine data collection systems needed for monitoring the maternity services at a national level, and in many regions, actually deteriorated during the 1980's ... As a consequence there is currently no national information on matters as basic as the extent to which caesarian section is being used for delivery"

and also stated that:

> "Information derived from systematic reviews of controlled research has shown that there are effective forms of care which have not been sufficiently widely adopted, and that there are forms of care which are hazardous (or likely to be ineffective) which continue to be offered within the maternity services".[112]

Also, Wendy Savage, a consultant obstetrician has written:

> "The caesarian section rate has risen without adequate thought or careful trials to determine which level of surgery produces the best results".[113]

[109]Ev p 188
[110]MS125
[111]Ev p 184
[112]MS50
[113]MS207

89. The Vaginal Birth After Caesarian (VBAC) Information and Support Group drew the Committee's attention to the possibility that women who had previously had a caesarian section would have the same intervention unnecessarily in a future pregnancy despite the greater safety and superior outcome of VBAC over repeat elective caesarian section.[114] The Caesarian Support Network carried out a survey and obtained information from 94 hospitals. It was very difficult to draw safe conclusions from these replies. The VBAC Group stated that women should have choice in relation to method and place of delivery. If a caesarian section is undertaken,

> ".. all efforts should be made to provide the anaesthetic of the woman's choice ... Fathers and/or birth supporters should be permitted in the theatre if the mother wishes, regardless of type of anaesthetic employed. Some mothers find photographs/video of the lift-out of the baby extremely helpful to their subsequent emotional well-being and we would like to see this facilitated where possible".[115]

90. In her study of women's experience of epidurals Sheila Kitzinger highlights how important it is for a woman to feel in control of her decisions about interventions and how this can affect her overall experience of giving birth:

> "All those who were entirely positive about their experience of birth with an epidural felt free from any pressure to have the epidural ... Choosing to have an epidural was for them empowering rather than incapacitating.
>
> In contrast, women who later regretted having an epidural had usually been under pressure to accept one ...".[116]

91. The NCT gave oral evidence on women controlling their own management of pain as follows:

> "... if a woman feels she is in control of her labour, if she is actually choosing what is happening, she knows the person who is looking after her, she knows their attitude to pain in labour, she knows her attitude to pain, then she is going to have a much more satisfactory experience whatever happens to her".[117]

One of the mothers who gave evidence to the Committee believed that:

> "... this is a pain that is a positive pain that is going to get somewhere; every contraction leads you to the birth, and those forms of psychological pain relief are as powerful as the other and if a woman expects she can get through the pain herself she will and if she is offered pain relief then she might well take it whereas she could have got through without it".[118]

92. A woman who had her baby in hospital in Hampshire was given woefully little information about interventions during her labour:

> "I was in a lot of pain; I was *told* I would have Pethidine and gas & air - never asked whether I wanted these, although I had during my pregnancy said I did not want them. The effects of these left me feeling detached from my body, still feeling all the pain and petrified that I would fall off the bed. Nobody ever told me that I did *not* have to lie down all the time"[119]

93. The NCT, AIMS and Maternity Alliance all reiterated that women need maximum and timely information before being offered a particular procedure in intrapartum care.[120] Protocols or guidelines need to be agreed between midwifery and obstetric staff about the provision of such information and for intervention rates to be monitored routinely in all maternity units over time.[121]

94. Some women prefer the use of alternative therapies to more conventional methods of intervention and this is one reason cited for choosing a home birth if they are likely to be denied access to such methods in hospital.[122]

95. We also received evidence that younger mothers, single mothers, those from minority ethnic groups and the less well-off had particular difficulty in communicating with professional staff and felt less happy about the treatment they received during labour.[123]

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[114]MS156
[115]ibid
[116]MS1B
[117]Q795
[118]Q1583
[119]MS245
[120]MS277, Ev p 91, Ev p 235
[121]Changing Childbirth, Maternity Alliance, 1989
[122]Q1563, MS422
[123]MS163 1.8

96. **We conclude that until such time as there is more detailed and accurate research about such interventions as epidurals, episiotomies, caesarian sections, electronic fetal monitoring, instrumental delivery and induction of labour, women need to be given a choice on the basis of existing information rather than having to undergo such interventions as routine.**

The birthing environment

97. As Sheila Kitzinger points out in her written evidence, there are interventions of a more subtle nature that can affect the environment in which birth takes place:

> "They include having to put on a hospital gown, being put to bed as if you were ill, not being able to eat and drink when you want to, the constant checking of labour against the clock, being surrounded by strangers who talk over you and about you, rather than to you ..."[124]

98. The Institute for Social Studies in Medical Care in its written evidence cited research that found that mothers being allowed, if they so wished, to have a partner, friend or relative with them at delivery, and being allowed to hold the baby as soon as he or she was born, were associated with greater satisfaction with maternity care.[125] A recent father who gave evidence to the Committee believed:

> "The man's role ... is nowhere near as important as the woman's and the child's, but I think the importance comes in, in my experience and the experience of virtually everyone else I have talked to, that the husband is very important to the woman ..."[126]

99. With regard to the environment the Committee also received disturbing evidence from the NCT that standards of cleanliness in hospital bathrooms often fell far short of what one would expect of a healthy environment:

> "... we hear time and again of women using bathrooms and lavatories which are quite clearly just not cleaned. There is blood around. There are used towels around. They are filthy".[127]

The NCT also told us of their concern about postnatal infection. Ms Lewison said:

> "... I think for many women their first few days with a new baby can be ruined by a very painful postnatal infection in addition perhaps to an episiotomy and that can interfere with breast feeding and the bonding relationship between the mother and the baby".

She also said:

> "I do not think postnatal infection statistics are collected nationally".

When asked whether cleanliness in hospitals had a bearing on this problem, she said:

> "I think that is a serious factor for women, yes".

We conclude that there is a need to establish methods of monitoring levels of significant postnatal maternal infection to ascertain the extent of this problem and whether it is growing.

100. **We conclude that the experience of the hospital environment too often deters women from asserting control over their own bodies and too often leaves them feeling that, in retrospect, they have not had the best labour and delivery they could have hoped for.**

Postnatal Care

Lying-in

101. In the evidence submitted to the Committee women express a wide variation of needs in terms of how long they need to stay in hospital or other unit after giving birth. This variation often correlates to the extent of support they expect to receive when they return home.

102. The Committee spoke to women at the neighbourhood maternity units in Bath district and it was clear that the women appreciated the ability to stay in the units as long as they wished. However, there appears to be a general trend contrary to this practice whereby women are being encouraged to go home earlier than in the past. The Maternity Alliance raised concerns that the reduction in the average length of stay postnatally should not be achieved at the expense of the health and well-being of women and their babies.[128] In particular, they highlighted the need for lying-in wards not only in rural areas, but also in urban areas for young and single mothers,

[124]MS1
[125]MS163
[126]Q1585
[127]Q770
[128]Ev p 94

homeless women and those living in unsuitable accommodation, women with heavy domestic responsibilities and those who have had multiple births.[129]

103. Similarly the NCT stressed the importance of enabling each woman to participate in deciding the length of her postnatal stay in hospital.[130] In oral evidence, Ms Phillips of the NCT stated,

> "We are not saying that a reduction in hospital stay is *per se* a bad thing...but the consumers who led it were very largely middle class consumers who had the kind of resources to make sure they did have back-up".[131]

104. Linked to women's needs in relation to the length of postnatal stay is the level of social support which women receive when they return home. Both the NCT and Maternity Alliance pointed out the lack of home helps available in the community, despite the fact that women postnatally have the statutory right to domestic help from home care assistants.[132] Because of pressure on resources women feel that others in the community, such as older people, have a greater need for this limited support.[133] Women with disabilities and those who have had caesareans or multiple births are particularly needy of the home help service.[134] Health professionals should not automatically assume that women from minority ethnic groups would necessarily have an extended family network to give support.[135]

105. Another aspect of support for which women have expressed a need is that of postnatal support groups which have proved a lifeline for many women, like those established by the NCT.[136] The Committee was also told of the importance of telephone helplines for housebound women and for people who need immediate help.[137]

106. Women who experience postnatal depression need speedy and appropriate care, whether offered in the form of listening and support, practical assistance to enable rest and physical recovery, or drug therapy.[138] They need to be offered support by health professionals who are adequately trained to recognise and assist with postnatal depression.[139]

107. Training in awareness of special needs sometimes appears to be lacking. For example, the Committee received evidence that few women from minority ethnic groups are helped with postnatal depression, perhaps because of a 'lack of effective communication or appropriate counselling, the belief in the myth of the extended family or the notion that postnatal depression is a western phenomenon'.[140] Similarly, women with hearing problems also face difficulties getting appropriate counselling for postnatal depression, as very few counsellors can sign, and using an interpreter is not often an appropriate option.[141] Women who have given birth to twins or greater multiples of children also have special problems coping.[142]

Breastfeeding

108. The most important features with regard to women and breastfeeding elucidated in the evidence presented to the Committee were once again those of choice, information and continuity of care.[143] **Whichever feeding method a mother chooses to adopt she needs advance information and support to enable her to establish the method of her choice, and she needs expert advice and strong support after birth until she is confident about her chosen method of feeding.**

109. However, for mothers who wish to establish breastfeeding, there is evidence that they have particular needs. Maternity Alliance stated that as breastfeeding is recommended particularly for the first four months of a baby's life, women need paid maternity leave for this period so that

[129]Ev p 93
[130]Ev pp 259-260
[131]Q312
[132]Ev p 259, Ev p 94
[133]Ev p 259
[134]Ev p 94, MS156, MS198 7.4
[135]Ev p 260
[136]Ev p 95
[137]ibid
[138]Ev p 265
[139]Ev p 97
[140]ibid
[141]ibid
[142]MS198
[143]Ev pp 268-273, Ev p 96

financial hardship does not pressurise women to return to work prematurely.[144] Many women who are homeless need a more nutritious diet and a better physical environment if they are to continue breastfeeding beyond the first week or two.[145] Women with two or more babies need extra help and moral support with breastfeeding.[146] Women who have undergone caesarean section and wish to breastfeed need a great deal of help to overcome the pain experienced in picking up the baby and achieving a comfortable feeding position.[147]

110. The trend towards earlier discharge also has implications for mothers trying to establish breastfeeding as mothers are often discharged before they produce milk. On the other hand, mothers often find that being in hospital itself is not conducive to establishing breastfeeding, despite the professional help which should be available there. Getting back home, and being provided with good support there, is often the best way. In its oral evidence the NCT stressed that postnatal visiting by a midwife should continue as long as is necessary to allow the mother to establish satisfactory breastfeeding.[148]

After bereavement

111. The Committee received evidence about what women need when they are faced with the traumatic experience of losing their baby, whether in the form of delivering a dead fetus, having a stillbirth, a miscarriage or a termination.

112. The Stillbirth and Neonatal Death Society (SANDS) stated,

> "When a baby is known to have died in utero, no matter at what stage of pregnancy the death occurs, sensitive management of labour and delivery is essential. Parents retain vivid memories of their baby's birth ...Good care can give them some positive memories among their many sad ones, and this can help them to grieve".[149]

113. The Committee's attention was drawn to detailed recommendations for the management of labour and delivery after death in utero in SANDS' "Miscarriage, Stillbirth and Neonatal Death: Guidelines for Professionals" 1991.

114. Support after Termination for Abnormality (SATFA) states that mothers undergoing abortion for fetal abnormality at any stage of pregnancy require that psychological support and bereavement counselling be readily available in addition to sensitive physical care.[150]

> "Some have found being on a labour ward with other pregnant women giving birth very distressing. Others have found that being on a gynaecological ward can add to their sense of isolation and failure in motherhood".[151]

115. SATFA recommends that parents should be given a side room to address this problem and that parents should be offered, in a sensitive manner, the opportunity to hold the dead baby if they wish.

116. Women who lose their babies, whether through miscarriage, termination, death in utero, stillbirth, or neonatal death, need particular support and sensitive care to help them come to terms with their loss. The Guidelines for Professionals drawn up by SANDS, commended by many of the other witnesses, amply detail women's and parents' needs during this difficult time and include the need for: parental consent for pathological investigation; consultation with parents about a respectful method of disposal of the dead baby, including those born dead at less than 28 weeks of gestation; a certificate and/or burial or cremation according to the parents' choice and cultural or religious preference; communication between hospital and community services to avoid duplication and insensitive care; bereavement support and counselling.[152] **We recommend that the guidelines drawn up by SANDS should form the basis for training of all professionals and managers involved in maternity care for dealing with bereavement. All units should ensure that such training is given to staff in a properly designed way.**

117. A recent publication by SANDS entitled, "A Dignified Ending" gives recommendations for good practice in the disposal of bodies and remains of babies born dead before the legal age

[144]Ev p 96
[145]ibid
[146]MS198 5.13
[147]MS156
[148]Q778
[149]MS196 3.1
[150]MS44 5.1
[151]ibid 5.2
[152]Miscarriage, Stillbirth and Neonatal Death: Guidelines for Professionals, SANDS, 1991

of viability.[153] These recommendations include: giving parents written information about hospital policies and procedures on disposal and the choices available, and, if appropriate, help to decide what is done with the body or remains of their baby; and that all staff involved in the care of parents following pre-28 week loss should know about the hospital's policy and procedures for disposal, should receive training and support and should communicate with other staff and departments involved in handling the bodies and remains of pre-viable babies. **We commend them to all hospitals.**

118. In its oral evidence SATFA gave the Committee examples of where communication between the hospital and community services was woefully lacking, causing the mother even more distress:

> ""..we have had many parents who have actually received letters saying, "Why did you not turn up for your last antenatal check-up?" and the mother has had the termination of pregnancy in that hospital".[154]

119. SATFA pointed out the importance after termination for abnormality of a detailed post-mortem to confirm the abnormality and determine the condition which affected the baby, so that there is accurate information available for future genetic counselling.[155] Women who have had a termination need forewarning that they will lactate unless they are offered drugs to prevent the milk forming.[156]

120. **We conclude that the evidence highlighted the overarching need for professionals to take account of best practice in this area and to formulate coherent and sensitive policies to address the needs of parents and families who experience miscarriage, stillbirth and neonatal death.**[157]

The Wider Context

Maternity Benefits

121. As part of our inquiry into maternity services *'as a whole'* we looked at the help provided by the Department of Social Security for women during pregnancy. While few of our witnesses from the field of epidemiology were prepared to commit themselves as to the relative contributions of social and medical factors to the decline in PNM rates, no-one alleged that factors such as nutrition and housing had no impact on the outcome of pregnancies. We therefore concentrated on the arrangements that exist to provide help for women on low incomes, particularly through the Income Support and Social Fund schemes.

122. We received evidence from the Maternity Alliance and others that emphasised the importance of a 'good diet' during pregnancy and the preconception period, and which noted that women on a low income would incur extra expenses if they were to eat the kind of diet that was recommended by antenatal clinics. We take it as a matter of common sense that people should eat sensible foods in adequate amounts, particularly during pregnancy, and we believe this is generally accepted. The DHSS noted as long ago as 1977 that:

> "An inadequate diet before and during pregnancy may impair growth of the baby and put at risk the health of both mother and child".[158]

We do not believe that all the difficulties faced by mothers in feeding themselves during pregnancy result from lack of knowledge about good food, rather we believe that major difficulties arise from poor material circumstances and low income. The view that it is the behaviour of mothers and mothers-to-be, that is the sole cause of children being unhealthy is not one to which we subscribe. Our view is broadly no different to that expressed by one of the earliest commentators. In his report on poverty in York in 1899, Rowntree observed that if York was typical,

> "then the impediment to the rearing of healthy children is not the ignorance of the mothers so much or nearly so much as that the conditions of modern life do not enable them to supply their children with sufficient sustenance".[159]

123. The Maternity Alliance drew our attention to the difficulties that women on low incomes could face in taking the advice of the DHSS:

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[153]MS414
[154]Q1300
[155]MS44 5.12
[156]ibid 6.1
[157]MS3A, MS196
[158]DHSS 1977 Reducing the risk: safer pregnancy and childbirth, HMSO
[159]quoted in *Poor Citizens* D Vincent Longman 1991 p35

"Eating healthy food in pregnancy need not cost more than eating healthy food at any other time. Many women on low incomes eat an inadequate diet, however, or cut back on food for themselves because food is one of the few elastic items in their budget. In order to eat the recommended healthy diet in pregnancy, women on Income Support may find that they need to spend more".[160]

124. The Maternity Alliance has calculated the cost of a diet considered adequate for pregnant women, based on diet sheets used in maternity hospitals. Using figures for 1988, this diet was priced at £14.06 per week. This took account of the one free pint of milk per day which pregnant women on Income Support are entitled to claim. As a percentage of the Income Support rate, Maternity Alliance calculated that £14.06 represented 51 per cent of the rate for a single woman aged 18-24, 68 per cent of the rate for a single woman aged 16-17, or 26 per cent of the rate for a couple aged 18 or over.

125. We asked DSS officials in oral evidence about the amount in Income Support that is intended to meet the cost of an adequate and healthy diet for pregnant women. Mrs Susan Maunsell, Under-Secretary at the Department of Social Security, told us that:

"Income Support is intended to cover all day-to-day expenses. There is not a specific amount for diet".[161]

126. Mrs Maunsell pointed out that some of the Maternity Alliance's calculations were based on rates that would apply to women not living independently. Furthermore, a woman who is single and on Income Support is entitled to an increased rate on the birth of her first child, and will also receive a family premium and a lone parent premium. A 16 or 17 year old woman living independently is entitled to receive the same rate of Income Support as a single woman aged 18-24, that is, £31.40, rising in April 1992 to £33.60. A table provided by the DSS in a supplementary memorandum that shows the Income Support applicable amounts for single people and couples with up to 2 children is shown.[162]

127. Even after including the various increases and premiums to which a pregnant woman may be entitled, it is apparent that the percentage of income that would need to be spent on food by a pregnant woman on Income Support is a considerably higher proportion than other women are likely to spend.

128. We asked DSS officials what research the Department conducted into the amounts spent on food by pregnant women on Income Support. Mrs Maunsell told us:

"The indications that we have are that an adequate and healthy diet can be afforded within the basic income support level".[163]

Mr Peter Tansley, Assistant Secretary at the DSS, supported this view and implied that the view was based on monitoring of Income Support:

"... our advice is that generally speaking a balanced and adequate diet need not be expensive and the monitoring of income support generally suggests that it is entirely possible to obtain an adequate diet within the levels of income support".[164]

Mr Tansley admitted, however, that the advice available to the DSS was general, and did not relate specifically to the cost of an adequate diet in pregnancy or the food spending patterns of pregnant women on Income Support:

"We have not conducted research directly relating to what people spend on food or on the question of dietary needs. We have professional advice, of course, about dietary need which shows that a balanced and nutritious diet can be obtained in a number of ways which need not be particularly expensive".[165]

129. We questioned the DSS officials to establish how, if a Government department was to take a view that the current level of Income Support made it 'entirely possible' to afford an adequate diet during pregnancy, they did this without any evidence on which to base this view. Mr Tansley replied:

"The basis for my statement was the advice we received about people meeting the basic needs of nutrition. There are a number of ways that might be done. It is not a case of having

[160]Ev p 84
[161]Q1113
[162]MS417
[163]Q1114
[164]Q1115
[165]Q1116

one particular diet, but a number of ways of meeting basic requirements for nutrition. The report I mention, published last July, was a fairly dense scientific report which explained what was required in terms of particular nutrients and work continues on that. There may be other reports coming out in due course which give more direct advice about food. My reasons for linking that to the adequacy of income support were simply that the experience of people in the field and our ongoing monitoring of the scheme suggests that we have no evidence to point the other way, that people are having significant difficulty in obtaining an adequate diet".[166]

130. Mr Tansley made reference to a report for the Department of Health by the Committee on Medical Aspects of Food Policy in July 1991.[167] The report had as its terms of reference: 'To review the Recommended Daily Amounts (RDAs) for food energy and nutrients for groups of people in the United Kingdom.' The report therefore dealt exclusively with nutrition, and did not set out to price an 'adequate diet'. This report does not, we believe, represent research into the adequacy of Income Support for providing a suitable diet for pregnancy, nor does it represent research into the food expenditure patterns of pregnant women on low incomes.

131. We recognise that there is no breakdown of the rates of Income Support according to the amounts paid to meet daily expenses. Benefits are not broken down into specific amounts allocated for food, fuel or clothing costs, and there is no element identified for pregnancy or women with young children. The same position applied to the Supplementary Benefits scheme. We also acknowledge that it is the policy of the Government to provide general help through Income Support basic amounts, combined with premium payments to groups considered to be in extra need. The Government consultation paper issued prior to the reform of social security in 1986 stated:

"The proposals ... base entitlement on age and marital status; familiy responsibilities; and client group membership".[168]

132. The Maternity Alliance, however, suggested to us that a premium for pregnancy should be paid in the Income Support scheme, in the same way as the family premium, to help meet the extra costs of pregnancy.

133. **We conclude that the Department of Social Security cannot comment with authority on the adequacy of Income Support rates for providing a balanced diet for pregnant women in the absence of research to support its view. We therefore recommend that the Department of Health and the Department of Social Security conduct research specifically into the food purchasing and food consumption patterns of pregnant women in receipt of Income Support.**

134. We were puzzled that policy should seek to make a distinction between pregnant women on grounds of age. We could not fully comprehend the reasons for paying a different rate of Income Support to pregnant women aged 25, 24 and 17. As Christine Gowdridge, Co-ordinator of Maternity Alliance, observed:

"It seems to us that a pregnant 24-year-old is no different from a pregnant 26-year-old and should not get significantly different amounts of benefit, let alone pregnant 16 and 17-year-olds".[169]

135. The DSS told us that the reasons for this age difference lay in the review of supplementary benefit conducted in 1986/87, and the reforms of the social security system that took effect in 1988. Mrs Maunsell outlined the thinking of the Government at that time:

"... there were two rates of benefits, householders and non-householders. That was obviously not something that we wanted to continue, or that the Government at that stage wanted to continue. It was decided that in order to help the people who had the greatest expenses, who were the over-25s, these differential rates would apply. It was also true that the Government of the day had incentives very much in mind and that for younger people one did not want to construct a benefit system which would encourage people not to seek work".[170]

In addition to considerations of expenses and work incentives, the DSS found that family responsibilities increased with age:

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[166]Q1180
[167]Dietary Reference Values for Food Energy and Nutrients for the UK Department of Health HMSO 1991
[168]Cmnd 9518 2.39
[169]Q294
[170]Q1122

"... the under 25s had fewer family responsibilities and were much more likely to be living with family and friends and did not have the expense of fully independent living".[171]

But figures derived by the House of Commons Library from OPCS Birth Statistics suggest that the mean average age of women at first birth outside marriage is 22. As these are about 27 per cent of all births it suggests a good many under-25s with family responsibilities.

136. The decision to pay different rates of Income Support to people aged under 25 was therefore based on a general assessment of the relationship between age and household or family responsibilities. The DSS informed us that the cost of paying the same amount to all under 25s including those who are not pregnant, would be £250 million. Supplementary information provided by DSS estimated that to pay pregnant women aged 18-24 the same rate as those aged 25 and over might cost £4.5 to £5.5 million.[172]

137. The circumstances of pregnant women aged 16 or 17 were of particular concern to the Committee. Births to teenage mothers are in general undesirable because of the risks to the health of both mother and baby; the greater likelihood that teenage families may face adverse social and economic circumstances; and evidence which suggests that teenage marriages are very likely to result in divorce. **We conclude that to compound the risks to very young mothers with the setting of benefit levels on the assumption that where teenage women are pregnant family and friends will in all cases provide support for the young woman is putting such mothers and babies at further unnecessary risk. We recommend that pregnant 18-24 year olds who qualify for Income Support should receive it at the full adult rate.**

138. Since 1988 it has not been possible for people aged 16 or 17 to claim income support. Pregnant 16 or 17 years olds may claim Income Support in a period eleven weeks before their baby is due and for six weeks after. Certain other specified circumstances, such as a severe mental or physical disability, may also mean that under-18s may claim Income Support. In other circumstances, a pregnant woman aged under 18 must apply to the DSS for a severe hardship payment. This scheme was established in September 1988 following the withdrawal of general entitlement to Income Support for under 18s, and applications are considered if a claimant is unemployed and registered for work and a place on a Youth Training Scheme. This scheme is not designed to help all pregnant teenagers. As Mrs Maunsell explained:

"Pregnancy alone is not a reason for claiming income support, but any young person between 16 and 17 may at any time seek to have his case for income support considered under the special hardship rules".[173]

139. Mr Michael Jack, Parliamentary Under Secretary of State at the DSS, has previously outlined the arrangements that exist for income support, training and severe hardship payments:

"All pregnant girls aged 16 or 17 years can get income support under normal rules for the 11 weeks prior to, and for six weeks after, their confinement. During the earlier stage of pregnancy they can get income support if they are incapable of work, but the remainder are guaranteed the offer of a youth training place. For those on youth training, training allowance replaces income support. The Secretary of State for Employment has taken measures to ease access to appropriate youth training provision for pregnant girls, the aim of which is to provide training relevant to their needs. The severe hardship provisions within income support provide the necessary discretion to enable sensitive handling of such cases and for financial, housing and social circumstances to be taken into account".[174]

The basic assumption is that pregnant 16 and 17 year olds, like their non-pregnant peers, will be on Youth Training. The training allowance itself is different according to age, being £29.50 at 16 and £35 at 17. So a pregnant 16 year old on Youth Training has to manage on £29.50 whatever her other circumstances. When she stops Youth Training, which she is entitled to do at 11 weeks before the birth, she qualifies for Income Support and gets only £23.65, whereas an unemployed pregnant 26 year old on Income Support would get £35.65.

140. Between December 1990 and November 1991 2,495 pregnant women aged 16 or 17 claimed income support on grounds of severe hardship, and four-fifths of these claims were successful.[175] A survey conducted for the DSS by MORI in July 1991 found that a quarter of all 16/17 year old women claiming help from the Severe Hardship Unit were pregnant. The qualitative findings of

[171]Q1123
[172]MS417
[173]Q1134
[174]Official Report, 13.2.91 c531 w
[175]Official Report, 15.12.91 c84 w

the MORI survey support the evidence this Committee has received concerning the extra costs of pregnancy:

> "All had extra current expenses, mainly relating to dietary needs - only a few were managing a balanced diet, although most said they were trying to eat more protein. It was not just a lack of any finance that caused problems, but difficulties paying for particular things; one girl could not get free prescriptions because she was not on Income Support. Even those on benefit felt that their financial situation could be better. They were also concerned about how to pay for things they would need after the baby was born, including better accommodation, clothes for the baby, and care".[176]

141. **We recommend that where 16 and 17 year olds qualify for income support, either under the normal rules or under the severe hardship arrangements, benefit should be paid at the full adult rate. Where a 16 or 17 year old is on Youth Training, then the allowance should be increased to equal full adult rate Income Support. We can see no reason for a policy to discriminate against pregnant women on grounds of age, and we do not believe that this was the original intention of the Government.**

142. The statutory part of the Social Fund includes a lump sum maternity payment of £100, which is payable to those on low incomes (that is, the woman or her partner must be in receipt of Income Support or Family Credit). The DSS informed us that the estimated cost of Social Fund maternity payments was £18.7 million, paid to 172,000 women. With around 700,000 births in England and Wales per year, we were surprised that this maternity payment, aimed at low income families, would be paid to about one quarter of all families. Mrs Maunsell told us:

> "£100 has always been intended to be a contribution to the costs of a baby, not the full cost of having a baby ... Before the social fund payments started people just got £25 ... so £100 was a substantial increase for those people who were really thought to need it".[177]

143. It is true that the universal flat rate maternity allowance of £25 no longer exists, but a more accurate comparison is between the Social Fund and the single payments from the supplementary benefits scheme, which were replaced by the Social Fund. Under the supplementary benefits scheme, up to £187 was available for items required for a maternity. £187 in April 1987, when the last supplementary benefits scheme uprating took place, is worth £249 at December 1991 prices.[178]

144. We believe it is appropriate for the Government to review the level of the Social Fund maternity payment. £100 is considerably less than many mothers in need of assistance might have received under previous arrangements, and is apparently paid to one quarter of all new mothers. It is clear that it makes a very limited contribution to the purchase of the items necessary to ensure young babies have a chance of healthy development. **We therefore recommend that the DSS conduct research into the contribution to the costs of maternity made by the Social Fund maternity payment.**

145. Multiple births represent a very small proportion of the total, but they are increasing as a result of infertility treatments. We have received evidence from the Twins and Multiple Births Association[179] and from the NPEU[180] about the special problems families face in these circumstances. **We recommend that the DSS and Department of Health also review their benefit arrangements to ensure that local offices can take full account of the special needs of families which have experienced multiple births.**

146. Statutory Maternity Pay also presents some problems, especially of entitlement. There are two rates. The Higher Rate gives 6 weeks at 90 per cent of her average earnings and 12 weeks at £44.50. To qualify for the Higher Rate a woman must work for the same employer for either a minimum of 16 hours per week for two years, or a minimum of 8 hours per week for five years, continuing into the 15th week before the expected birth date. She must also have average weekly earnings of at least £52 (between April 1991 and 1992) during her specified eight weeks.

147. To qualify for the Lower Rate she must have worked for the same employer for 6 months continuing into the 15th week before expected birth date, and have average weekly earnings of at least £52 during the eight weeks before that. She then qualifies for £44.50 for 18 weeks.

148. Information about the number of women in receipt of Statutory Maternity Pay is difficult to get, but it appears from House of Commons Library figures to be about 275,000 women per year.

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[176]A survey of 16 and 17 year old applicants for severe hardship payments, MORI/DSS July 1991
[177]Q1145
[178]Figures supplied by HoC Library
[179]MS198
[180]Three, Four and More, HMSO, 1990

(Total births are about 700,000 per year). Published figures do not distinguish between women getting Higher Rate and women getting Lower Rate.

149. Two problems arise here. One is the long qualifying periods for entitlement to the Higher Rate. The other is the need to earn at least £52 for the specified eight weeks. The eight weeks earnings are interpreted very strictly so that, for instance, if a woman's earnings for a particular week are actually paid in another week, perhaps because of holidays, or if she has some time off without pay, or if her hours or bonuses fluctuate, then she may well lose her entitlement even though her earnings over a longer period average £52. This is too arbitrary a measure. **We recommend that the Department of Social Security review urgently all the terms and qualifications for Statutory Maternity Pay with a view to addressing the problems which we have identified.**

150. We are also concerned about the position of women who are at work in low paid employment which after the birth of the baby would entitle them to receive Family Credit, and **we recommend that the position of women working in low paid jobs be evaluated to determine whether Family Credit should be extended into pregnancy.**

151. When the Government comes to respond to our recommendations in this field, we hope that, in considering the immediate costs of any of the measures we have recommended, they will show evidence that they have taken into account the effects of poverty and poor nutrition on the health of mothers and babies which have to be picked up through the social services and health budgets.

Maternity Leave

152. The Maternity Alliance also informed us of their view of the inadequacy of the present provision for maternity leave entitlement. Much of this is not due to the absence of entitlement but rather a failure of the system. Maternity leave in the United Kingdom is long but, as we have seen above, largely unpaid. Even good employers have difficulty operating the system of maternity pay. The Department of Social Security guidelines are good but we still hear of employers who do not understand the provisions. There are also employers who still operate the old scheme which disappeared in 1987.[181] The onus is on women to find out their entitlement, not on the employers to tell them. Many women thus fail to obtain benefits and rights for which they have fulfilled all the conditions. The problem is particularly severe with small employers who have little experience in operating the scheme. If there are problems with the scheme where there is good will between employer and employee, they are compounded when it is absent. A pregnant woman is dependent on the employer for her maternity pay and its administration. And many women fear to challenge employers' decisions because the two year qualifying period leaves them unprotected against unfair dismissal.

153. The Committee therefore took the opportunity of discussing with the DSS the latest position with respect to the European Commission's draft Directive concerning the protection at work of pregnant women and women who have recently given birth.

154. The Government had had serious reservations about the Directive, in particular about the status of a Directive to guide a Member State's social security system, and their concern that it sought to impose unnecessary restrictions on the employment of women and unjustified burdens on employers. The Committee understands the Government's reservations about the Commission seeking to bring the proposal forward under Article 118a, which is concerned with the health and safety of workers. We were also concerned that the Commission's note regarding the economic impact of the proposal contained no estimate of cost, a fact noted in a recent report from a House of Lords Committee.[182]

155. However, it does appear to this Committee that the United Kingdom Government has laid itself open to the accusation that it is only interested in the effects the Directive would have on employers and on HM Treasury - the Government does not appear fully to have addressed the question of whether the proposal would be of benefit to the women and children concerned. Sir David Price, in questioning Mrs Maunsell of the DSS, summed up the position:

> "In the real world can one make these rather nice distinctions which may suit divisions in Whitehall between health and safety and social security? In the real world, in terms of a pregnant woman at work, surely they all come together, do they not?"[183]

[181] Ev p 86

[182] 2nd Report from the House of Lords Select Committee on the European Communities, Session 1991-92, HL 11, para 18

[183] Q1156

156. The Committee believes that when the Directive was "allocated" to Departments, it was a serious oversight that the Department of Health did not have co-responsibility, alongside the Department of Social Security and the Department of Employment, although we trust that the Department of Health did at least have some input into the discussions. The Committee also believes that it was a mistake to regard this Directive as just a matter of occupational health. **We conclude that maternity leave is significantly a matter of public health - it should not be overlooked that the health of the unborn or newborn child is also at stake.**

157. The Committee is pleased to note that agreement has now been reached on the proposed directive, and looks forward to its earliest possible implementation by the UK Government.

Complaints

158. When things go wrong with the maternity services, women need a complaints system that meets their needs. AIMS defines these needs as: the truth; a genuine apology; action to ensure the mishap is not repeated and information on how this will be done; and appropriate disciplinary action or further training for staff where warranted.[184]

159. However, the Committee received evidence of the inadequacies of the current complaints procedures for maternity care. On the one hand, it is apparent that women find making a complaint too complicated, stressful and often fruitless after their birthing experience. On the other, it is clear that professionals' practice is influenced by their fear of litigation, implying a failure in the complaints procedure.

160. We have been made aware of the concern expressed by the professional groups, particularly the obstetricians, about the increasing use of litigation to seek redress for a possible complaint about care. The RCOG said:

> "The likely consequences of these actions on clinical practice in Britain are worrying. There is considerable professional anxiety due to the experience in the United States of America that the threat of medico-legal action will lead to more restrictive practices, resulting in an increase in costly investigations and deliveries by caesarian section".[185]

They recognised however that:

> "many medico-legal actions can be avoided by a full and frank discussion between the consultant concerned and the patient as soon as possible after the event".[186]

161. The view of the users of the services was given to us by Action for Victims of Medical Accidents (AVMA) and by AIMS. AVMA identifies that:

> "much is being made recently by the obstetricians about the threat to medical care posed by the increase in litigation and the amount of damages awarded in the most serious cases. They suggest that matters are moving in the same direction as the United States and that as a result, young doctors are not going into obstetrics".

But they go on to say:

> "Cases are not brought against obstetricians for damages for brain damage to babies unless it is clear that there has been unacceptable medical practice. Before a case can be started, it is absolutely essential that the Plaintiffs obtain a medical report from a Consultant Obstetrician which identifies specific areas of substandard care. It goes without saying that damages are never recovered unless a judge finds that there has been substandard care and settles the case.
>
> If the obstetricians are under pressure therefore, it can only be that more cases of substandard care are being identified and successfully litigated".

162. Mrs Jean Robinson of AIMS told us in oral evidence that:

> "It is the complaints procedures that we are concerned about because they are not meeting the needs of the complainants".[187]

She described the difficulties experienced in making complaints against general practitioners; the fact complaints against GP and hospital services require two different approaches which

[184]MS277 13.8
[185]Ev p 146
[186]ibid
[187]Q1195

> "do not mesh, so any complaints that relate to the lack of integration of those two forms of care are not dealt with by anybody and it requires an emotional and intellectual marathon from the family concerned, which they are unable to cope with".[188]

Mrs Robinson also described the differences between being able to achieve a satisfactory outcome when an approach about alleged professional misconduct is made, between the General Medical Council (which deals with doctors) and the United Kingdom Central Council (which deals with midwives).

> "When we complain to their professional body (UKCC) we find that in general that professional body takes those complaints very seriously indeed. We do not have similar confidence with the General Medical Council".[189]

We understand that the GMC have acknowledged that their complaints system is not entirely satisfactory, and that they are seeking to address some aspects of this problem. We welcome this and hope that time will be found for any necessary legislation at an early opportunity. **We conclude that the complaints system is failing to achieve the purpose for which it was designed, at least so far as the maternity services are concerned. This failure may be causing earlier and more frequent recourse to litigation which itself is undesirable.**

163. Evidence presented to us suggests that women who do not placidly accept what they are told by professionals risk being stigmatised as "cheeky"[190] and are therefore discouraged from questioning or complaining. In giving oral evidence, Ms Nash told the Committee she was reluctant to persist on the issue of having access to her own notes because her experience working for a health board in Scotland,

> "made me very worried about making myself unpopular in the hospital where I was to give birth".[191]

164. The inadequacies of the complaints system were more critically exposed in an anonymous letter from a woman who described the barriers she encountered when attempting to make a formal complaint about her experience of giving birth in hospital. Firstly, she emphasised the delay in dealing with her complaint; it took over a year from the time the formal complaint was made to reaching the stage where Independent Professional Review was established. Secondly, she was insensitively handled to the extent that at one point a senior member of the hospital staff promised that she would be treated "more humanely" from then on. Finally, the woman in question felt intimidated because she was treated as a potential litigant from the outset and consequently felt the process to be adversarial rather than constructive. In particular, she was told that an essential prerequisite to the full investigation of her complaint by the Regional Medical Officer was a written disclaimer that she did not propose to undertake legal action. Such a disclaimer is of questionable legal status and has no basis in formal policy or legislation, but non-compliance is still used as a barrier to further investigation of a serious complaint. We express our serious concern at the use of such a disclaimer and ask the Department of Health to investigate the extent of this practice.

User feedback and participation

165. A responsive and accessible complaints procedure forms an integral part of a comprehensive system of user feedback, which in turn informs the quality assurance process. The Government emphasises the importance of placing patients' interests paramount[192] and therefore should ensure that there are adequate mechanisms to enable this to happen, in the maternity services as much as in any other area of provision.

166. Dr Mary Hepburn of the Royal Maternity Hospital in Glasgow stated in her written memorandum

> "If we are to provide services which women want to and are able to use, it is vital that we take their views into consideration. Women should therefore be asked why they do or do not use various facilities and what services they want or need and how, where and by whom, they would like the services delivered".[193]

[188] ibid
[189] Q1196
[190] Q1571
[191] ibid
[192] Cm 555
[193] Ev p 69

167. However, the Committee has received evidence that women are not being given sufficient opportunities to make their views known and that existing mechanisms need to be strengthened. For example, the NCT in its written evidence stated that,

> "Currently, users of the maternity services are not made to feel their experience is important to the providers of care. Positive and negative comments could be used by managers to improve the running of hospital and community services, as part of on-going training for medical and midwifery staff..."[194]

and in their oral evidence they said,

> "A major concern of ours is the lack of opportunity for service users to influence policy and practice".[195]

168. Whilst OPCS have produced a standardised survey[196] to enable DHAs to carry out surveys of women's views of the service, few health authorities have availed themselves of this opportunity. It appears that this is a result of lack of resources and lack of the appropriate information technology to do so. A survey undertaken for South East Thames RHA[197] has shown that it is both practical and feasible to investigate consumers' views and choices of maternity services and to use the information in the planning and provision of services.

169. Via the contractual process health authorities are vested with the responsibility of purchasing services that meet the needs of their resident populations. Therefore, if women's views on maternity services are to inform purchasers' intentions and decisions, service users should be fully involved at the planning and monitoring stages of the contractual process. The NHS Management Executive, recognising the notion of user involvement generally in purchasing, has recently issued a paper, "Local Voices: The Views of Local People in Purchasing for Health" encouraging health authorities to draw on the views of local people at appropriate stages during the purchasing cycle.

170. More specifically, the Association of Community Health Councils for England and Wales (ACHCEW) has highlighted the importance of involving users in contracting decisions and has produced a series of consumer standards and checklists which purchasers would do well to consult when placing and monitoring contracts for maternity services.[198]

171. Although the Department of Health cited the strengths of Maternity Services Liaison Committees (MSLCs) the Committee also received evidence that MSLCs are not fulfilling their intended function of providing the opportunity for consultation and joint planning. The NCT stated in their oral evidence,

> "They do not actually have any powers to implement policy and frequently they are ignored".[199]

and it was stated that there was a need for Departmental guidance as to whether MSLCs should relate to purchasers or providers. **We conclude that, at present, Maternity Services Liaison Committees are failing to provide women using the maternity services with a fully effective channel to influence the shape of provision of those services.**

172. The evidence we have reviewed in this chapter suggests very forcibly that the maternity services, as they are currently organised and provided, fall short of meeting women's needs. All too often maternity services have been shown to be inaccessible and inappropriate for reasons of geography, lack of appropriate information and support for women from minority ethnic groups, lack of facilities for women with disabilities, inadequate financial support for women on low incomes and insufficient staff training in counselling, in disability and wider awareness of the needs of particular groups.

173. Even the most articulate and assertive women, with access to a range of information, have described to us barriers encountered in trying to achieve their chosen method and place of birth. This begs the question of how less advantaged women can gain access to the type of maternity care they would like. Pronouncements about the need to provide women with choice, continuity of care and control are wanting in purpose unless the inequalities in health between different groups of

[194]Ev p 237
[195]Q752
[196]MS411
[197]MS409
[198]MS427
[199]Q792

women are acknowledged and addressed. This is a prerequisite to placing women at the centre of the planning and provision of maternity care.

174. **We conclude that there is a need for: well-designed and appropriate levels of maternity benefits; the provision of information in appropriate forms and languages on the options available at every stage of care; the provision of linkworker and advocacy schemes where required; the opportunity whenever possible for women to remain in the hospital or unit until sufficient social support is available on discharge; and the training of staff in counselling skills and awareness of the special requirements of different groups of women. Moreover, the complaints procedure requires a thorough review if it is to provide users of maternity services with an effective mechanism for gaining emotional, practical or financial redress.**

CHAPTER III: THE EVIDENCE FROM THE PROFESSIONALS

Introduction

175. While it is clear from the evidence we have analysed in the previous chapter that there is a large measure of consensus among women about what they want from the maternity services - emotional support, continuity of care, a confident and confidence inspiring birth attendant, choice and control over their own bodies - the evidence from the professionals about what they believe women both want and need is less clear cut. Much of what we heard appeared to be concerned with which group should have control over the maternity services, and we analyse these apparent rivalries elsewhere in this report. There is also a considerable difference of opinion among professionals (though also some consensus) about what women, in their view, need in terms of medical supervision, control and intervention, and we analyse these views under the headings of antenatal, intrapartum and postnatal care. Differences of opinion in this area appear to stem from divergent philosophies of the management of pregnancy and childbirth, between what has been frequently described to us as a 'medical' and 'non-medical' view of the process.[200] But we begin our analysis by considering the evidence we have of the degree to which the professionals involved in the maternity services have acknowledged and are responding to the broad demands of women that we have already identified: choice; control; and continuity of care.

Continuity of Care, Choice and Control

176. The main evidence we have received on all these issues has come from the representatives of the three principal professions involved in maternity care: the Royal College of Midwives (RCM), the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of General Practitioners (RCGP). Of these, the RCM were, as they themselves said, the most radical in their proposals for change.[201] In acknowledging the importance of continuity of care[202] they laid great stress on their conviction that midwives were best placed to provide this,[203] saying 'Midwives are concerned with the entire reproductive health of women ... women should be able to refer themselves directly to midwives ... Domino Schemes which enable community midwives to deliver their own clients in hospital might also be extended.'[204] They summarised their position as a call for 'a midwifery led maternity service providing continuity of care to defined caseloads of women within a specific geographical area'[205] and asserted their conviction that such a midwifery led service would improve outcomes for women.[206]

177. At the same time the RCM lay considerable emphasis on 'the right of women to be full partners in their care'[207] or as Ms Lesley Page succinctly put it in oral evidence 'It is particularly important that she [the mother] has control over her own body and the birth of her own child...'[208]

178. The Association of Radical Midwives (ARM), who describe themselves as the 'think tank of the profession',[209] estimate that

[200]Ev pp 115, 122, 232, 236, MS76, Q395
[201]Ev p 399
[202]Ev p 115, p 119; QQ 447, 968
[203]Q970
[204]Ev p 115
[205]Ev p 399
[206]Q 984
[207]Ev p 115
[208]Q 950
[209]MS76

> "most women in the UK meet at least 25-30 different midwives throughout the process. They also meet anything up to 10 different doctors and their contact extends to Student Nurses (doing maternity care module), Nursing Auxiliaries, Domestics, Ward Receptionists - by the time the whole process is finished they end up feeling exhausted and confused ..."[210]

It has to be said that this estimate is far in excess of the averages we have heard from other witnesses. Again, the solution that the ARM propose is the establishment of team midwifery and a 'midwifery-led' service, but they identify the medical model of childbirth as the main impediment to the delivery of such a service, quoting "The Role of the Midwife"[211]:

> "It appears to be readily acknowledged that the midwife is responsible for the care of normal childbirth, but perhaps one of the main threats to the execution of that role is the practical application of the philosophy that childbirth is only normal in retrospect".[212]

179. The Association of Supervisors of Midwives also told us that 'Midwives are attempting to find solutions to the issues surrounding continuity of care.'[213] Support for the principle of continuity of care was also expressed to the Committee in written evidence from other midwives.[214]

180. The RCM summarised their position in the statement which opened their written evidence:

> "The principles on which the [RCM's] evidence is based include:
>
> — the right of women to be full partners in their care, to have access to high quality care and to receive clear and honest information enabling them to exercise choice.
>
> — the right of midwives to practice their profession in a system which makes full use of their skills to provide full clinical care throughout pregnancy, in labour, at delivery and in the postnatal period and which respects their legal accountability".[215]

While we would have no disagreement with the first of these principles, we are cautious about accepting that any one group has a 'right' to practice their profession which overarches the right of another group, or more importantly, might take precedence over the needs of mothers. We believe this has in the past been a way of thinking which has had adverse consequences for the maternity services.

181. Evidence about views on the importance of continuity of care from the other professions involved was sketchier and in places more qualified. The RCOG in their memorandum stated that 'Midwives should ... be able to provide intrapartum as well as antenatal and postpartum care for women in the community',[216] but when challenged on this assertion in oral evidence it seemed to us that they had not confronted the implications such a claim might have in its practical application to the organisation of the maternity services.[217] The witnesses from the RCOG did not cite continuity of care or, until they had been encouraged to commit themselves several times,[218] even mothers' satisfaction when asked to give their criteria for good maternity care.[219] Although they lent their support to the principle of providing 'the maximum choice to the mother' the RCOG added the rider 'consistent with the best possible level of care.'[220] While we have no objection to this qualification in principle, and indeed accept that it is part of the duty of doctors to make such judgements, we were concerned that in practice the RCOG do not, in the face of conflicting evidence, acknowledge the possibility of any disadvantages to a hospital birth.[221] Later in this chapter we will explore in more detail the validity of the evidence on the extent to which women's choice should be constrained by judgements of obstetricians and paediatricians about what is the best possible level of care.

182. However, Professor Richard Beard, who acted as a specialist adviser to the Social Services Committee in its 1980 report on perinatal and neonatal mortality, and who also gave evidence on behalf of the RCOG, has written:

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[210] MS76
[211] ibid, & op cit, published jointly (1983) by The Central Midwives Boards for England and Wales, and for Scotland, The Northern Ireland Council for Nurses and Midwives and An Bord Altranais
[212] MS76
[213] MS27
[214] MS58, MS71, MS81,
[215] Ev p 115
[216] Ev p 140
[217] QQ 902-911
[218] Q878
[219] QQ 875-7 and 882-3
[220] Ev p 139
[221] Q917 ff

"The maternity services provide care, by and large, for healthy young women. It is no longer acceptable to provide that care without the informed agreement of pregnant women and their partners ... Attitudes must also change among professionals to ensure that complexity of care is not used as an excuse to impose management without achieving some understanding by the woman of the issues involved".[222]

Professor Beard's acknowledgement of the need for change shows that obstetricians are also recognising the need for a significant shift of emphasis in the way maternity care is delivered.

183. The shift of emphasis was also picked up by the RCOG in their written evidence where they stated that "Maternal choice should ... be based on informed discussion of screening and prenatal diagnostic tests, and of the risks of the options available".[223] However, in oral evidence it seemed to us that the presumption by the RCOG in favour of a hospital confinement and a medical model of care would inevitably continue to compromise the degree of even-handedness that was likely to be introduced by many obstetricians into that exchange of information.[224] The RCOG are fully entitled to hold to their opinions, but we were glad to hear that they feel they are becoming more open to the criticisms which have been voiced of the way in which maternity care has developed over the last decade or two.[225] Mr Simmons, the President of the RCOG, summarised his position by saying

"We have become, if anything, slightly too mechanistic in our approach to obstetrics ... too much science, too little caring; too little compassion, too much intervention. I accept that and I think it is something we, as a profession, need to address and we are being called to address it".[226]

While some of the evidence we have heard might lead us to challenge the qualification 'slightly', we welcome Mr Simmons's statement as a recognition of much of what we have heard from the women who have given evidence to this inquiry. Miss Mellows of the RCOG believed that "every woman would like to be looked after by the same midwife, antenatally, and then by the same one in labour".[227]

184. While the RCGP also acknowledged the growing demands for women to have control over their own pregnancy and childbirth and for continuity of care, they felt that the GP was best placed to advise on this saying "With her general practitioner she should decide where such care should be provided and by whom".[228] They reiterated this view in oral evidence, saying "I think it has to be the GP [who is best placed to provide continuity of care]".[229] They appeared to acknowledge, however, that at present the system of maternity care was falling below the ideal which they described in their memorandum on antenatal care thus:

"Good maternity care provides a basis for sound health and requires to be properly resourced and organized to provide a personalised service for each mother. Maternity services should be flexible and thus cater for the woman's physical, social, emotional and educational needs".[230]

Nonetheless, we detected in the evidence of the RCGP a continuing adherence to a somewhat medicalised and paternalistic pattern of service delivery, and rather less evidence than shown by the RCOG that they accepted the need to reappraise their own role in the maternity services.

185. This viewpoint is by no means universal among GPs. While strongly defending the role of the GP in maternity care, the Association for Community Based Maternity Care (which has recently changed its name from the Association for General Practice Maternity Care) laid great emphasis on the issue of continuity. This is a multidisciplinary organisation of GPs, Midwives and Obstetricians, but with a substantial predominance of GPs.[231] In their memorandum they state:

"Although there is no evidence to show any objective benefit produced by seeing the same carer at each visit, it should make it easier for women to discuss their worries, and

[222]MS313
[223]Ev. p139
[224]QQ 896-900
[225]Q881
[226]Q500
[227]Q474
[228]Ev p 218
[229]Q661
[230]Ev p 219
[231]MS47

consequently for the carers to give appropriate explanations and reassurance. Consumer surveys show that women prefer care from one person they can get to know and trust".[232]

186. Dr Sandy Cavenagh went on in oral evidence to stress that 'the small team has advantages in confidence, in relaxation and continuity.'[233] Dr David Jewell also listed the involvement of women as a criterion for judging the quality of maternity care, saying 'it is important that the experience should be good for women emotionally and one of the most important things about that is that they should be involved in terms of the decision making that is going on and that they should feel they are part of that and that the care should be accessible to them.'[234] The principle of continuity of care was also supported in a letter to the Committee from Linda Parr, a GP practising in Trowbridge, Wiltshire.[235]

187. There is more encouraging evidence that the importance of allowing and encouraging patient choice has become widely accepted. Many of the submissions from the providers of care, whatever their professional discipline, stressed the importance of giving women choice about their pregnancy care. The Department of Health said that "women should as far as is practicable be able to choose and have access to the type of care which they feel is best suited to their needs".[236] The RCM stressed that "all women should have the right to make their own informed choice on the place of birth. If a non-medical model of care is available as an option, women are more likely to perceive real choice exists".[237]

188. The RCOG stated that the wishes of the mother should play an increasingly important part in the management of labour and it is no longer acceptable to provide care without the informed agreement of pregnant women and their partners.[238] Jane Melia and colleagues who had undertaken a study of consumers views of the Maternity Services stressed that "there is increasing recognition that consumers views should form one component in evaluation of quality of care as well as providing an input into the planning procedure."[239] Accepting the fact that granting or supporting patient choice might mean that their decisions might differ from that of their advisers, Professor Beard stated "it would be wrong to deny women who do not accept the arguments for hospital delivery the opportunity of having a home delivery that is as safe as possible".[240]

189. The Department of Health stated in its evidence that "the aim of everyone concerned with childbirth must be to ensure the safety and health of mother and baby and to make the event a satisfying and happy one for her, her partner and her family"[241] and the Royal College of Midwives in its oral evidence stated that "pregnancy must be recognised as a life event and therefore there are other criteria [than maternal and perinatal mortality rates] which need to be looked at. We should base our indicators of value on the value which is important to that human life event, such as developing confidence in parenting, happiness at the outcome of having your baby, as well as looking at the health of the mother and baby. Another important aspect is the sensitivity with which the mother has been treated".[242] Miss Brain, President of the RCM, stated "that care should be consumer orientated and that women should be given a real choice of a non-medical model of care."[243]

190. Perhaps the most convincing research evidence relating to continuity of care and choice for women that has been produced to date is again from the NPEU in Oxford. This is most baldly summarised in Appendix 4 of their publication *Care in Pregnancy and Childbirth; A synopsis for guiding practice and research* which is entitled 'Forms of care that should be abandoned in the light of the available evidence.' The first two items listed are:

"Failing to involve women in decisions about their care.

[232]ibid
[233]Q 1428
[234]Q1396
[235]MS120
[236]Ev p 182
[237]Ev p 122
[238]Ev p 144
[239]MS340
[240]MS313
[241]Ev. p 181
[242]Q950
[243]Q395

Failing to provide continuity of care during pregnancy and childbirth".[244]

However, as we have seen in the evidence reviewed in the previous chapter, while there may be a commitment in principle to giving choice to women, in practice women too often experience their choice as constrained. The words of the leaders of the various professions involved in the maternity services do not yet seem to have been put into action by those on the ground.

191. In her oral evidence, the Minister of Health, Mrs Virginia Bottomley asserted 'the clear merits of women knowing their midwife and having the security and the confidence of knowing the person who will take them through what is an extremely important event in their lives scarcely needs underlining.'[245] **The evidence we have received suggests that the importance of continuity of care needs underlining very heavily for the professionals who are involved in delivering the maternity services of the NHS. Many still demonstrate an insufficient awareness of its prominence among the criteria which women use to judge the quality of the care they have received. Nor have they yet done nearly enough to respond in practical terms to the call by women to be involved as full partners in the decisions made about their care.** There are many honourable exceptions among the professionals, but we are certainly not persuaded that the message which has come over loud and clear to this Committee from women who use the maternity services has been heard and acted upon with sufficient commitment and vigour by those providing their care. **We further believe that the discussions we have heard about the case for providing continuity of care and the enabling of women to control their own pregnancies and deliveries have been far too heavily influenced by territorial disputes between the professionals concerned for control of the women whom they are supposed to be helping.**

192. The most explicit acknowledgement of the existence of alternative philosophies of maternity care was made by the RCM in their written evidence. They argued that:

> "the present system of maternity care is based on a "sickness" model, although childbirth is a normal physiological event and a "health" model would be more appropriate. It is assumed that all women require a specialist obstetrician although most care is provided by midwives and general practitioners. Currently women have little choice as to who provides care and the number of professionals involved can reduce the continuity of care which evidence shows does much to promote a good outcome to pregnancy and childbirth. Duplication of care leads to unnecessary intervention and is wasteful of resources".[246]

193. We now turn to consider the extent to which these differing and apparently competing philosophies of maternity care are reflected in more detail in the evidence we have received from professionals under the headings of antenatal, intrapartum and postnatal care.

Antenatal Care

Introduction

194. A woman's experience of antenatal care greatly influences her experience of intrapartum and postpartum care; it is a vital preparatory and learning period that often determines the extent to which she will experience continuity of care and be able to exercise choice at the next stages. If the experience of antenatal care is negative it may cause stress and anxiety offsetting the beneficial effects of the care itself and may encourage non-attendance by some women, leaving them outside the system of professional care.

Organisation and management of care

195. Dame Janet Campbell, who was one of the first women in medicine, recognised a need for starting a national system of antenatal clinics with a uniform pattern of visits and procedures. With little modification this practice still continues with additions of more sophisticated screening tests. However, we received considerable evidence that the piecemeal development of antenatal care had led to a situation now where:

> "The current provision of antenatal service is a mixture of traditional clinical laying-on of hands with a patchy provision of complex tests, whose availability often depends as much on the whims of Health Authorities' ideas of priority as on the needs of women and their fetuses".[247]

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[244] op cit
[245] Q805
[246] Ev p115
[247] MS131

196. There was a broad level of agreement in the evidence we received that the current pattern of provision of antenatal care was failing to deliver what was appropriate either to the perceived needs or the established wishes of mothers. Most importantly, it appeared that it was ill-designed to provide care that would ensure that the pregnancy, birth and postnatal period were made more likely to be positive experiences for women. While the Department of Health told us that

> "The aims of the antenatal care are to assist a woman to have a healthy pregnancy with a successful outcome both for her and her babies; to help the woman, her partner and family understand and enjoy her pregnancy and feel confident about caring for the baby after birth; identifying risk factors which are associated with a potentially adverse outcome, so that the effects might be minimised; and if complications arise to select the best time and mode of delivery".[248]

we heard from Dr Marion Hall, a consultant obstetrician that

> "Because a scientific basis for much of it is lacking, antenatal care is often inappropriately delivered, especially in respect of uncomplicated low risk pregnancy. Such women are seen more frequently than is really necessary because of inflexible adherence to out-dated routines".[249]

and Professor Symonds expressed his belief that

> "The current form of provision of antenatal care leads to fragmentation and lack of transfer of information".[250]

197. A tradition has arisen in the UK that pregnant women should be seen every four weeks until the 28th week, then fortnightly until the 36th week and then weekly. While attention needs to be given to the demand from women for access to their carers, we have seen the evidence in the preceding chapter that this leads to crowded waiting rooms and a reduced time during consultations for proper consultations, the need for which was described to us by Professor Chamberlain in written evidence:

> "Antenatal care is an ideal opportunity for women to express their anxieties, concern and wishes regarding pregnancy and labour.
>
> Advice can be given regarding financial and other benefits. Information can be given regarding options available to them regarding the place and procedures involved in childbirth. It would be an opportunity to encourage expressions of mothers' own wishes - birth plans may help to do this".[251]

There was broad agreement that the present system of antenatal care does not facilitate this. Dr Hall again said in her evidence:

> "Present schedules of antenatal care are almost certainly not cost effective and routine care could be reduced with an individualised programme of individual care for each woman according to her needs".[252]

and the RCOG has recommended[253] that women with normal pregnancies probably need only four or five antenatal visits. An article by Professor Chamberlain in the BMJ, however, warned that:

> "When pioneers have tried to reduce the number of visits from the traditional number, there has been resistance from older obstetricians, conventional midwives, women having babies and their mothers, all of whom think that Campbell's by now traditional pattern must be right".[254]

198. However, as Professor Chamberlain notes above, "women having babies" do not always appear to want a reduction in the number of antenatal examinations although they often find them

[248] Ev p 172
[249] MS86
[250] MS68
[251] MS130
[252] MS86
[253] Q1459
[254] MS118

tiring, inconvenient and unsatisfactory. While concerned to eliminate wasteful use of resources, we would be reluctant to recommend anything which reduced women's sense of security. It may well be the case that the common need to feel supported could be better met by more informal contact, such as a telephone link (which may solve the problem or suggest that a visit is necessary) or a community setting which encourages a woman to drop in if she feels concerned about anything rather than by the present rigid programme of visits. On our visits we did hear of such informal contact being offered, but we do not think it is common. If it were to become normal, then it should be possible to tailor the number of visits to fit more closely the situation and condition of the individual woman.

199. The RCM considered that "the present system [of shared antenatal care] fails to make the best use of existing resources". They also believed that it failed to "utilise the professional skills and abilities of the midwife".[255] They expanded this argument in oral evidence, stating their unsurprising belief that if there was duplication of effort they believed the GP should give way, rather than the midwife. Miss Rider told us that:

> "I think that we really have come to question the continuation of the duplication of care in the community by both the midwife and the GP ... what we are really saying now is that we think the time has come for us to take a radical re-look at the responsibilities of the three key professions involved in the maternity services ... the role of the GP ... should be to only provide the medical support for the woman while she is in the community, in the same way as happens when she is not pregnant. In that way ... we will not be duplicating expensive manpower, we will be breaking down the systems which can be open to bad communications ... and conflict of advice ..."[256]

200. The RCGP, when asked about the use of manpower resources, agreed with the widespread perception that "in the sphere of antenatal care ... often there is too much duplication"[257] and agreed that, with respect to the team providing maternity care in the community "... we are moving away from the days when the GP assumes as of right that he is the leader of the team".[258] In their written evidence they expressed the ideal that antenatal services "should be designed so that they are integrated and cost-effective"[259] but they stressed in oral evidence that what they were against was "moving the GP out of the field".[260]

201. When asked whether there was a role for obstetricians in the care of the normal pregnant woman Dr Waine, Chairman of the Council of the Royal College of General Practitioners replied "I would have thought that in most cases not"[261] while the RCOG in their evidence emphasised that "Women must be confident that there is close cooperation between hospital and community, GP, midwife and consultant; that the care is individualised and is wholly in her (the woman's) best interest"[262] but that for antenatal care in low risk women the combined team of General Practitioners and midwives in the community was most appropriate.[263] This was supported by Miss Gillian Turner, a Consultant Obstetrician who underlined the frequently made point that "These women are ideally cared for by midwives."[264]

202. This theme was picked up by Professor Calder and his colleagues in their evidence, again quoting Enkin and Chalmers' recognition of the "Growing belief that midwives can give as good, if not better care than doctors providing that there is a sound referral system to the specialist for patients identified as at risk"[265] and similar views were expressed by Dr Redman, who confidently asserted that "The greater part of antenatal care to women with uncomplicated pregnancies should be given in the community with a minimum of involvement of specialist services."[266] Again Sir Malcolm Macnaughton, ex-President of the Royal College of Obstetricians, believed that "The low risk patient could be cared for in the community and mainly by midwives."[267] Mr Malcolm Pearce

[255]Ev p119
[256]QQ 447-8
[257]Q659
[258]Q685
[259]Ev p 219
[260]Q680
[261]Q688
[262]Ev p 141
[263]Ev p 140
[264]MS144
[265]MS73
[266]MS132
[267]MS110

also supported the proposition that "Much is to be said for the establishment of community midwife clinics that look after low risk women" while expressing his view that "The role of GPs is patchy. In some areas GPs are [not] interested and much of the care usually is carried out by midwives ... However, choice should include full consultant care if she (the woman) wishes."[268] Mr Marwood, a consultant obstetrician with the Riverside Health Authority in London, commenting on the team midwifery development, said "Delivery of care should be based on the belief that wherever possible care should be community based."[269]

203. Dr G N Marsh, a GP from Stockton-on-Tees, states in written evidence that:

> "There is probably no more wasteful area in the National Health Service than the present system of maternity care. Gross overlap and duplication takes place between community midwives, general practitioners, hospital based midwives and consultant obstetricians and their junior staff".[270]

and

> "There is a continuing groundswell of maternal discontent with the 'over-medicalising' of the whole process. Care is often inconvenient for mothers. It needs to be community based not hospital based".[271]

On the interface between the midwife and GP he suggests

> "The routine antenatal care will be undertaken by the community midwife, but the GP will be available for
>
> (i) continuity of care and psychological support
>
> (ii) minor abnormalities in the pregnancy
>
> (iii) co-incidental illnesses treated at home or in the surgery
>
> (iv) occasional examination of the mother at salient points to support the midwife".[272]

204. The Royal College of Midwives described "shared care" thus:

> "The present pattern of provision of antenatal care was largely determined in the early 1970s in response to the Peel Report which prescribed that birth should mainly take place in hospital, in effect the DGH. Thus all women, except the minority who are delivered by a GP or midwife in small local hospitals or at home, are booked into a bed belonging to a consultant. The obstetrician is able to assume overall responsibility in the antenatal period for all pregnant women booked into "his" beds even though the bulk of the care is likely to be undertaken by a midwife or GP".[273]

205. A great deal of the evidence we received indicated that pregnancy care should to a large extent be based in the community near to where the woman lives. The NCT recommended that

> "Midwives should be organised into small group practices and have specific case loads of women for whom they provide antenatal, intranatal and postnatal care".[274]

and

> "Community midwifery clinics should be established where midwives can be the first professional a mother encounters at the beginning of her pregnancy".[275]

206. The RCM proposed

[268]MS31
[269]MS93
[270]MS9
[271]ibid
[272]ibid
[273]Ev p 119
[274]Ev p 233
[275]Ev p 242

"the setting up of a community-based primary maternity service. Women should be able to refer themselves directly to midwives, who might be best organised in teams covering specific areas. Midwives should have their own caseloads rather than obtaining their clients through the medical structure. Local Midwifery Clinics would be a convenient source of care and advice. Direct referral by midwives to specialists where problems occurred would ensure the prompt provision of secondary care".[276]

207. This view was supported by the Royal College of Nursing:

"It is our view that maternity care has become too medically dominated and midwifery skills are being under utilised".

They further wrote:

"Those women in the low risk categories should be under the care of midwives only, midwives being responsible for the total care of these women throughout their pregnancy".[277]

In written evidence the RCOG stated

"The majority of women patients come into the low risk category and the time and money spent in this level of care has major resource implications. The general trend of moving most "low" risk antenatal patients away from consultant based antenatal clinics back into the community is supported. This care can be provided by the combined team of general practitioners and midwives in the community".[278]

208. From the evidence we have received from the professionals involved in maternity care **we are persuaded that the present imposition of a rigid pattern of frequent antenatal visits is not grounded in any good scientific base, and that there is no evidence that such a pattern is medically necessary. The identified needs of women for information and support during pregnancy can be met more effectively than happens at present. There is widespread agreement that this requires a more flexible system which is based in the community, not in the hospital. The present system of shared care between hospitals and the community should, by and large, be abandoned. Hospitals are not the appropriate place to care for healthy women.**

Community and Hospital Services

209. However, while there is broad agreement that antenatal care should, for women with normal pregnancies, be placed firmly in the community, concern was expressed to the Committee by various branches of the medical profession about the continuing need to ensure that avoidable mortality and morbidity are reduced. The triennial report on Confidential Enquiries into Maternal Deaths in England and Wales was one of the first national audit exercises, the earliest of which covered the years 1952-1954. The survey now covers the whole of the United Kingdom. The latest edition covers the years 1985-1987.[279] Maternal mortality has fallen from 67.1 per 100,000 total births in 1955-57 to the lowest ever in the UK, 7.6 per 100,000 births in 1985-87. This compares with 640 in Africa, 420 in Asia and 270 in Latin America although it is slightly higher than some other European countries. However, this should not be cause for complacency. There were still 139 deaths directly due to pregnancy during the triennium 1985-87, and the majority of these were associated with substandard care.[280] It is pointed out in the report that the two major causes of mortality since the 1970-72 triennium have been pulmonary embolism and hypertensive disorders of pregnancy,[281] mainly pre-eclampsia, responsible for 24 and 25 deaths respectively. The authors conclude that:

"All those involved in providing care for a woman with moderate or severe pre-eclampsia should be reminded that there are serious risks for the mother as well as the fetus".[282]

[276]Ev p 115
[277]MS105
[278]Ev p 140
[279]Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1985-1987, London HMSO ISBN O 11 321333 6
[280]ibid, page 144
[281]ibid, page 12
[282]ibid, page 144

210. The booking visit, or first visit, to a health professional regarding an established pregnancy, is the time at which the first assessment of risk is made. In this context, risk means the perceived likelihood of the pregnancy developing a predictable complication. At the present time, our ability to predict abnormality remains limited.[283] Although we can identify a sub-group of the population in which the majority of risk will occur, many women with pregnancies at risk of abnormality will have a normal outcome, and some women apparently normal at booking will develop complications. Nonetheless, prenatal screening and diagnosis relies largely on selecting women at increased statistical chance of a fetal or maternal abnormality, to define a sub-group to whom special tests may be offered.

211. The diagnosis of major congenital defects has been a major area of advance over the last ten or more years. The Royal College of Obstetricians and Gynaecologists told us that in respect of genetic screening and prenatal diagnosis:

> "This aspect of antenatal care is now applicable to .. all pregnant women, two percent of whom may unsuspectingly be carrying a fetus with a major abnormality".[284]

The College have pointed out that ultrasound can be used both for routine screening and for diagnosis, and that up to 70 per cent of major malformations can be diagnosed.[285] However, in many districts, women are not yet routinely offered a mid-trimester anomaly scan.[286]

212. In each district there needs to be an effective system for the delivery of prenatal diagnosis. The relevant recommendation of the 23rd Study Group of the Royal College of Obstetricians and Gynaecologists on Antenatal Diagnosis of Fetal Abnormalities was that:

> "Effective delivery of prenatal diagnosis (PND) cannot be achieved until each District General Hospital has a consultant obstetrician with a special interest in PND, to take responsibility for the organisation of ultrasound, invasive procedures, patient information and professional education".[287]

213. To ensure the success of such screening programmes, there needs to be an effective audit. The RCOG working party suggested that this needs an adequate malformation register.

> "Current systems (of PND) are inadequate because information is incomplete. For many (often individually rare) conditions there is merit in organisation of malformation registers at a regional level but interlinked nationally".[288]

Such registers require a cooperative approach between the various districts.

214. Professor Malcolm Ferguson-Smith, Professor of Genetics wrote: "Voluntary screening programmes should be available to all mothers."[289] We also had evidence of concern over the provision of genetic services. Dr Dian Donnai emphasised the need for co-ordination between the maternity services and the genetic services[290] and Dr Bernadette Modell told us that:

> "Part of the reason why the services are inadequately delivered is that nobody is responsible for ensuring that "community genetic services" are delivered to the community".[291]

We dealt extensively with the Genetic Services in our earlier report on Preconception.[292] At the time of agreeing this report we still await the Government's response.

215. Anne Rider, a midwife, suggested in her evidence that:

> "The obstetric team might screen all pregnant women once, probably at 20 weeks when the results of screening including ultrasound anomalies scan and AFP results are available. This could give obstetricians and the women of normal pregnancies confidence that the correct type of management has been agreed. It could also act as a social interview between the obstetrician and the woman from which the woman would be reassured that a full range of obstetric back-up services are available to her should a complication arise"

and that thereafter

[283]See e.g. *Pregnancy and Risk*, eds Stirrat and James, John Wiley & Sons, London, 1989
[284]Ev p 139
[285]ibid
[286]ibid
[287]Ev page 142
[288]ibid
[289]MS142
[290]MS22
[291]MS333
[292]HC (1990-91) 430-I, paras 122-138

"The patient would only need to be referred if the pregnancy continues over 41 weeks".[293]

216. As the majority of pregnancies are normal, and remain so, there is no *a priori* need for the medical profession to be further involved. There is debate about the stage at which it is appropriate to first involve obstetricians. Many feel that to wait till the 20th week of pregnancy is too late. Nonetheless, all agree that medical advice needs to be readily available in the event of an abnormality being detected.

217. In order to allow ready access for women needing obstetric care who are being looked after in the community clinics or at home Mr Garrioch, a consultant obstetrician, recommended developing a new type of "fetal assessment unit" with immediate access to specialist opinion,[294] and Mr McFadyen, also a consultant obstetrician, wrote:

"Day care facilities for monitoring at risk pregnancy have been shown to be effective".[295]

218. A study of the economics of such a system undertaken in Glasgow by Dr McIlwaine suggests that for certain groups of women, this type of care actually costs less.[296] **We conclude that there is a broad consensus among the professionals that the development of day care obstetric assessment units in hospitals, combined with community-based antenatal care, would allow for rapid referral of antenatal women for further investigations and specialist opinion.** Miss Brain, President of the Royal College of Midwives, told us:

"The midwife has to be able to refer directly to a consultant obstetrician, if during that antenatal visit she discovers that something is wrong ...[297] She will refer to the general practitioner, for example, for normal medical needs, and to her obstetric colleague when there is an abnormality, or a potential abnormality, obstetrically speaking".[298]

The Royal College of Nursing wrote to us that:

"Each district should develop policies for referral of women when complications arise. These policies should be agreed between midwives, GPs and obstetricians and should allow for easy transfer of care".[299]

We believe that the strengthened MSLCs that we wish to see would be the appropriate forums to develop such policies.

219. The RCGP were, however, unhappy about the proposals for direct referral by midwives to obstetricians. Dr Waine told us that this should happen only

"in collaboration with the GP. The referral system has stood us in good stead over the years ... I think it is wrong that people can be referred without the knowledge of the GP who is accepting 24 hour responsibility and should not have to be called to a patient where a referral has been made that he knows nothing about".[300]

We do not acknowledge much force in this argument. No-one is proposing that GPs should not be informed about such referrals. Any system must make adequate provision for the efficient and reliable exchange of information. That provision should remove the need for duplication by the GP of the midwife's role, and release some valuable time for them to meet some of the many other pressing demands which are placed upon them. **We conclude that the desirable development of community-based antenatal care, combined with ready access to specialist assessment, will best be advanced by the general acceptance of the right of midwives to refer women directly to obstetricians or other appropriate specialists. Systems to ensure the prompt notification of GPs of such referrals will be necessary. Continuity of care in these circumstances is likely to be facilitated by encouraging women to hold their own notes.**

Intrapartum Care

Introduction

220. Throughout our inquiry the issues relating to intrapartum care have centred on place of birth. To the extent that mothers do have a real choice about place of delivery, in this country that comes down to the options of a consultant obstetric unit within a District General Hospital; a GP

[293] MS88
[294] MS103
[295] MS115
[296] MS150
[297] Q399
[298] Q396
[299] MS226
[300] Q676

maternity unit, either attached or adjacent to a DGH, or relatively geographically isolated; and home. The evidence about whether such choice exists in reality has been examined in the previous chapter, and as we have noted the bald statistics give one perspective on the issue: for 1988-89 the Hospital Episode Statistics (HES) data suggest that 94 per cent of births took place in a consultant ward and 4 per cent in a GP ward, with the remaining 2 per cent divided equally between home births and private hospitals.[301] These figures have been fairly constant for the past ten years with the only change being a continuation of the steady move away from home births (down from 1.7 per cent in 1978 to 1 per cent.)[302]

221. The evidence about the place of birth which we heard from women has raised two fundamental issues relevant to our consideration of the development of maternity care for normal pregnancies; namely the conceptual model for that care and the issue of maternal choice. Throughout much of that evidence frequent reference has been made to the concept of the "medical" and "non-medical" or "woman-centred" orientation to maternity care.[303] The contrasts between them are particularly marked in the debate concerning place of birth, but are also highly relevant when considering the nature of intranatal care within the hospital setting.

Place of Delivery

222. Opinion amongst the professionals about the benefits of universal hospital confinement seems largely to reflect the point of view of the commentator. The major concern of the medical professions is with the complications of childbirth, and they are therefore naturally anxious to ensure that facilities to deal with the unexpected catastrophe are available to all.

223. With less than two per cent of women delivering at home, we were interested to assess whether this was perceived by professionals to represent the real demand for a domiciliary confinement. Miss Ashton, General Secretary of the RCM, stated

> "I think it is very clear to us that most women assume the place where they should have their babies is hospital and many women do not know that there is any choice or that there is any alternative way or place to have their baby... From our own experience at the College and through the experience of quite a lot of the organisations which we call the 'lay' organisations, there are very many women who do want to have a home birth but who, for a variety of reasons, are blocked from doing so or who have great difficulty. Our evidence shows that many, many women given the opportunity given an understanding of what is available actually go for choosing home birth".[304]

Two surveys we received in evidence suggested that between 5 per cent and 15 per cent of mothers would at least seriously consider home birth if they felt it was a real option.[305]

224. Ruth Cochrane, a London obstetrician, who undertook a research project in Tower Hamlets of women's feelings about maternity care found that 70 per cent were offered no choice regarding their place of confinement. "It is clear that even in Tower Hamlets where several GPs undertake intrapartum care, women are still not being offered a choice in the matter".[306] The RCM stated that "women who request a home delivery are often treated as deviant, faced with obstacles to achieving their aims, such as being threatened with being struck off their GP's list".[307]

225. The RCOG in its evidence told us "We consider that the safety of the mother and baby in labour are of paramount importance. Intrapartum care is particularly important because of the potential for the mother and/or baby to be endangered during labour without warning".[308] Professor Beard of St Mary's Hospital wrote similarly "safety for mothers and babies remains the major issue for obstetrics in planning the maternity services for the 90s".[309] The RCOG in its Maternity Mortality Survey writes "there is no room for complacency. Because we produce a high quality of care there is no reason to think that risks don't exist" and went on in their oral evidence to us to say

[301]Ev p 187
[302]Ev p 215
[303]see para 175 of this report
[304]QQ439-440
[305]MS189, MS411
[306]MS160
[307]Ev p 122
[308]Ev p 142
[309]MS313

"it would seem to us clear that we feel that the safest place is where the facilities are. The finest facilities will be in the biggest units, fairly good facilities in much smaller units, but these facilities would be better than no facilities at home".[310]

Nevertheless it seems clear to us that the quality of housing in terms of heating, sanitation and general hygiene has vastly improved during the ninety years in which we have witnessed a dramatic shift away from home births.

226. Professor Macnaughton, past President of the RCOG wrote "it is preferable that all women should be delivered in circumstances where immediate and skilled help is available, should an abnormality arise. If optimum care is intended, all women have to be covered. Any woman delivered without those facilities being available runs an increased risk which is not justifiable today. Any woman who requires to be transferred for delivery to a hospital from her home runs an increased risk for herself and the baby and this risk is avoidable"[311] and Mr McFadyen, a consultant obstetrician in Liverpool, said that "there are low risk and high risk pregnancies, but there is not a no risk group. Because all are at risk, the delivery suite is an intensive care area and should be staffed as such, both to deal with emergencies and to monitor mother and fetus in labour to prevent serious problems. More use of fetal scalp sampling should be encouraged".[312] He also remarked that "analgesia is required in almost all labours". When pressed on whether the RCOG regretted the closure of small maternity units, their President eventually said 'No'.[313]

227. Similarly, the British Paediatric Association wrote to us that:

"All of the babies born in consultant obstetric units require paediatric medical care during the new born period... Therefore all consultant obstetric units should have paediatric medical staffing and facilities should be present in all for immediate resuscitation at birth ..."[314]

This view was supported by Dr John Rudd, a paediatrician in Bath, who spoke to the Committee during our visit there. His view that avoidable deaths had occurred in the peripheral units in that health authority was based on evidence[315] the validity of which was challenged by other commentators, both locally and nationally.

228. The non-medical professions approach the matter from a different viewpoint, that of expecting normality. Thus the Royal College of Midwives wrote to us that a "non-medical model of care" should be available to all women and that "A home-confinement service should be an integral part of the maternity service.[316] Their antagonism to the medical model of childbirth is illustrated by their comment that "In some hospitals women still experience fetal monitoring, rupture of membranes, and augmentation of labour as routines. These practices ... are refuted by recent research. They also represent a misuse of NHS resources".[317] They also wrote "Good care in labour and delivery should be centred on the physical and psychological needs of the individual woman".[318] The RCM thus reject what they perceive as the "potential disaster" model espoused by the medical profession, and place much less emphasis on the need for emergency facilities if things go wrong. Thus in oral evidence they told us that it was not essential for there to be two midwives at a home birth, despite the occasional need in an emergency to deal with resuscitation of the mother and the baby and to summon help, all at the same time.[319] They also said, however, that an assistant was desirable, and that this role might be filled by a student.

229. They are supported in their view by the Midwifery Society of the Royal College of Nursing who wrote:

"That women in the low risk categories should be under the care of midwives only, midwives being responsible for the total care of those women throughout their pregnancy. Realistic choices for the place of birth should be available and should include home birth".[320]

230. Similarly the Association of Radical Midwives wrote to us that:

[310]Q908
[311]MS173
[312]MS199
[313]Q913
[314]Ev p 417
[315]MS406
[316]Ev p 122
[317]Ev p 133
[318]Ev p 123
[319]Q991
[320]MS226

"The recommendations of previous parliamentary committees that all births should take place in centralised consultant units run counter to all current statistical evidence ... labour care needs to be both decentralised and demedicalised".[321]

We conclude that there is an established need for the professionals involved in the maternity services to address the issue of providing women with a wider choice of place of birth and to consider ways of organising services to support that choice. More immediately, there is a need to establish ways of providing a choice of a less medicalised pattern of intrapartum care, whatever the setting. We note that the NPEU includes in its list of forms of care that should be abandoned in the light of available evidence "insisting on universal institutional confinement".[322]

Management of Labour

231. Much of the controversy surrounding the management of labour concerns the problem of finding an appropriate balance between the two orientations to care. This issue was addressed by Professor Whittle who said "the management of labour appears to be one of the most problematic areas for obstetrician, midwife and mother alike. On the one hand many obstetricians feel that labour is a potentially dangerous time for mother and child and yet in the vast majority of cases, no harm arises. The desire to keep a close watch on both mother and child have to be balanced with the consumer demand for a less invasive approach."[323]

232. A recommendation from the Royal College of Obstetricians and Gynaecologists in 1982 stated "to accommodate the wishes of pregnant women within the confines of safety for mother and child underline the difficult balance between ensuring that pregnancy was a good experience for the mother yet safeguarding clinical practice".[324] Moreover, more than 40 years ago the difficulty of finding a correct balance was recognised by the Joint Committee of the RCOG and the Population Investigation Committee report of 1948 in which it was stated "the maternity services cater in the main for healthy women going through a physiological process. Their needs are more complex than those of the sick where the clinical aspect is all important." **We are not persuaded by the evidence we have received that the current organisation of the maternity services for intrapartum care has yet succeeded in resolving these conflicts. In the oral evidence presented to us there was a clear indication of the potential for a damaging demarcation dispute between the professional groups over how labour should be supervised.** The Minister of Health said "What is wrong is for the woman to feel she is at the centre of a demarcation dispute".[325] **We wholeheartedly agree, and believe that there is an urgent necessity for the NHS and the Royal Colleges to address and resolve this dispute.**

233. Evidence of the failure to resolve this conflict was the considerable concern expressed by women that they were being subjected to unnecessary medical interventions intrapartum which were neither of proven value nor properly explained. Reference was made to the 'cascade effect'[326] of such interventions, that is, how a decision to induce labour might lead to the need for an epidural which in turn might lead to the need for instrumental delivery or caesarian section, perhaps resulting in a mother or baby needing special care in the immediate postnatal period. Ms Wendy Savage wrote to us expressing concern over the rates of surgical intervention in labour, particularly by caesarian section.[327] She highlights the fact that in the USA, section rates have reached 25 per cent of all deliveries (a five-fold increase over the last 30 years). A similar although more modest increase appears to have occurred in England, and within the national picture there appear to be statistically significant variations between different regions and between different hospitals in the same area for which no convincingly adequate explanation can be given other than variations in practice by obstetricians. There is also some concern that junior medical staff are liable to resort to surgical intervention in a particularly inconsistent way where there is insufficient consultant cover to provide them with the ready recourse to the advice of senior colleagues.

234. The results of an investigation of long term health problems beginning after childbirth in 11701 women in Birmingham was published during the course of our inquiry.[328] Among much useful analysis, the survey highlighted the surprisingly scant evidence of any serious attempt to follow-up the effects on women of interventions during childbirth. The authors found indications

[321] MS181
[322] Effective Care in Pregnancy and Childbirth, Appendix 4
[323] MS45A
[324] MS313
[325] Q834
[326] Q762
[327] MS207
[328] Health after Childbirth; MacArthur, Lewis and Knox, HMSO 1991

of correlations between chronic backache and the use of epidurals; between chronic headache and neckache and general anaesthesia and caesarian section; between tranquillisers given during labour and pain in the legs; between the use of inhalation anaesthesia and fatigue; between pethidine and neckache, weakness in the legs and tingling in the hands; and between caesarian sections and postnatal depression.

235. While the authors of the report are cautious about their conclusions, what concerns this Committee most greatly is the evidence of the failure of the medical and midwifery professions in the past adequately to audit the quality of its care in terms of maternal morbidity: perhaps a reflection of the over concentration on perinatal mortality as the only or overriding measure of success. Like other branches of medicine, obstetrics has been swept by fashions in which treatments have been introduced because they are available and not because they are of proven value. And, again as in other branches of medicine, procedures introduced to deal with specific circumstances become routine without proper evaluation. Perhaps the most outstanding example of this in recent times is the induction of labour. This rose from under 10 per cent of deliveries in the early sixties to a peak of almost 40 per cent of all deliveries in the early seventies,[329] since when it has shown a steady decline to about 12 per cent in 1988-89.[330] At the height of this fashion it is alleged that induction rates in some hospitals reached 70 per cent. Perhaps no other obstetric invention has done more to damage the reputation of the specialty, and consumer reaction to this may be identified as one of the turning points in the move away from the 'medical model'.

236. Similar concern has been expressed about whether the growth in the number of episiotomies performed on women can be explained by factors other than over-enthusiasm for this procedure on the part of the medical and midwifery professions. Between 1968 and 1978 the episiotomy rate rose from around 25 per cent of all deliveries to over 50 per cent of all deliveries[331] since when it appears to have fallen to around 35 per cent-40 per cent though the data have become unreliable. One of the many deleterious effects of an episiotomy was highlighted by Dr Waine of the RCGP who identified among the factors which can inhibit a woman from breastfeeding "the routine episiotomy, because I find it very difficult to see how the woman can go through the physiological process of breastfeeding when she is sitting on six grammes of barbed wire ... I think the selective use of that procedure would certainly be helpful".[332] We were astonished to learn on our visit to the NPEU in Oxford that, despite the conclusive evidence that the use of glycerol-impregnated catgut ('softgut') to suture episiotomies produced a much higher level of persistent perineal pain (often very damaging to the sex lives of couples) for up to three years after birth, this material (which is more expensive than traditional catgut) was still being used to suture women in maternity units in this country. This demonstrates an astounding failure by the medical and midwifery professions to effectively audit their own clinical standards.

237. It is appropriate at this point to again highlight the work of the National Perinatal Epidemiological Unit. The work which they have done in pointing the way towards evaluating the effects of different ways of organising maternity care cannot, we believe, be too highly praised. Their work has shown that many procedures and technologies have been introduced into intrapartum care over the last 30 years without adequate testing to ensure their efficacy and cost-benefit ratio. Their analysis has been published in the two volume *Effective Care in Pregnancy and Childbirth*,[333] and is now being made available on disk with the provision for continual updating. The Appendix to that work, which summarises the forms of care that should be abandoned in the light of the available evidence, makes daunting reading when we look back over the major developments in maternity care in the last few decades. Mr Rupert Fawdry, a consultant obstetrician in Milton Keynes, wrote to us:

> "We should be very aware of the massive achievement of this unit in clarifying what is known and what is not known about effective maternity care... I would strongly recommend that a copy be supplied to every community midwife in Britain".[334]

We would endorse his recommendation, but would add every obstetrician, paediatrician, general practitioner and hospital midwife in the United Kingdom to his list.

[329]Birth Counts, Macfarlane and Mugford, HMSO 1984, p161
[330]Ev p187
[331]Birth counts, op. cit. p161
[332]Q721
[333]Oxford University Press, 1989
[334]MS79

Postnatal Care of the Baby

Emergency Resuscitation

238. In a small minority of cases, babies may need urgent resuscitation. Where they are born in acute hospitals the facilities will be readily available. If more women were to give birth outside consultant obstetric units, the provision for urgent resuscitation will fall more upon midwives and will require a high standard of continuing training. We discuss those issues in some detail in chapter VI.

Routine Examination

239. At present, babies born in hospital are examined by paediatric staff for congenital and other abnormalities soon after birth and if they remain for more than a day or two, again before discharge.[335] A variety of screening tests are carried out, as explained by the Department.[336] With extremely rapid discharge home, it may be difficult to arrange for an examination by a paediatrician, and we asked Professor Hull of the BPA whether midwives could become responsible for the routine examination of babies.[337] He replied:

> "As far as them becoming the persons who do the first major appraisal of any child that is born, then that is a very big exercise and there are elements of it that midwives I am sure could do as well, properly trained .. as anyone else, but part of this examination includes listening to the heart and although they might be well trained to do that we are beginning to look at a training that is close to that of a doctor ..."

Professor Cooke of the BAPM stated:

> "I broadly agree. In our own practice midwives have largely taken over the role of the second examination. Most babies who are in for not more than a short time are examined first [by a paediatrician] at about 24 hours and then again before discharge. Provided no problems have arisen it is now routine for midwives to examine these children prior to discharge in order to speed up the discharge process because mothers stay for such a short time these days".[338]

There appears to be no reason why the midwife should not carry out the routine examination of apparently healthy newborn infants, provided she is well trained in the detection of congenital abnormalities and the subtle signs of impending illness. We discuss the implications for training in our final Chapter. However, we acknowledge that it is important that paediatric staff in training are not excluded from acquiring experience of the normal newborn infant. It is only against this experience that they will learn to judge the extent of any deviations from normal.

Neonatal Illness

240. The most dangerous time for babies is the immediate aftermath of birth, and they are most at risk of dying in the first 24 hours.[339] However, many illnesses or abnormalities in apparently normal babies do not declare themselves for several hours or days after delivery. If the baby is in hospital at the time, the problem can usually be dealt with speedily by the paediatric staff, with help from a range of readily available laboratory and other diagnostic support. Doctors, and paediatricians in particular, were anxious that with the increase in very early discharge of mothers and babies from hospital, these neonatal illnesses may not appear until after the baby has gone home. The same issue arises for babies born in small units or at home.

241. The first professional to be alerted is likely to be the midwife. Midwives training in neonatology obliges them to examine 100 normal babies.[340] Dr Rivers wrote "The midwife must be able to ensure that signs indicating the need for investigation or treatment are recognised".[341] We asked the Royal College of Midwives whether they regarded midwives as being competent to identify relatively unusual illness in a newborn baby, particularly if discharged from hospital very shortly after birth, to which Miss Anne Rider responded:

> "What is not understood by doctors as clearly as it should be is that the midwife's training is grounded in the normal and the skill in recognising the abnormal. If the midwife does not

[335]Ev p 418
[336]Ev p 189
[337]Q1097
[338]Q1098
[339]MS175
[340]MS76
[341]Ev p 431

act on that abnormality and refer to the medical staff she is likely to go through a very strong disciplinary action ..".[342]

However, Miss Rider acknowledged that illness in newborn infants can worsen very rapidly and, in considering the most appropriate pattern of referral for a midwife, concluded that:

"My ideal would be that that link would be into the neonatal paediatrician in the hospital because that is where we know that there are those skills. It may well be that some GPs have well-developed paediatric skills and can be used locally providing they are available on an emergency service, but we always know that there is a registrar available on call within the hospital, so that would be the first line of back-up, in my view".[343]

The Neonatal Nurses Association agreed:

"The community midwife should have direct access to the neonatal unit when this is required".[344]

242. Dr Colin Waine, the President of the Royal College of General Practitioners took a different view. He affirmed that it was the general practitioner's responsibility to deal with the matter[345] and stated "If necessary, he should seek the help of the paediatrician. The first point of contact should be the general practitioner.[346] Yet Dr Waine acknowledged that probably only 60-70 per cent" of GPs currently in practice have had any formal training in paediatrics.[347] This training is likely to have consisted only of a six-month house officer appointment with little experience in neonatal paediatrics which is not a mandatory requirement for training.[348]

243. For babies born in hospitals with paediatric cover, a chain of command exists from the house officer on duty through to the consultant on call, so that expert advice is readily available. For babies born in small units without paediatric cover, or at home, it is important that a clear policy is formulated by the Department for ensuring the well-being of the baby. **We recommend that protocols are drawn up in every district health authority and Health Board to ensure the rapid referral of babies becoming ill at home and requiring specialised attention. To facilitate this, the midwife should be able to refer directly to the paediatrician, while also notifying the GP of such referrals. This is a further task which it would be appropriate for strengthened MSLCs to undertake.** We discuss the implications for training of GPs and midwives later.

Postnatal Care of the Mother

Research

244. The evidence we received from professionals had relatively little to say about postnatal care of the mother compared to the other issues we have considered. Yet, as we have seen in the previous chapter, many women experience a need for a much higher level of support, even after producing a healthy baby, than they currently receive. This is particularly important where they are returning to adverse social circumstances of poverty, poor or non-existent housing and an unsupported domestic situation. This leads us to concur with the RCM in their conclusion that:

"despite its importance postnatal care does not have a sufficiently high priority. The College would welcome a wide-ranging investigation to determine a positive and co-ordinated programme to provide practical support to women".[349]

245. Fortunately, we received the report of just such an investigation at the very last stage of our inquiry. The Department of Obstetrics and Gynaecology and the Health Services Research Unit of the University of Aberdeen sent us an account of the empirical evidence of their research into postnatal care in the Grampian Region which surveyed a random 20 per cent of women delivered there between June 1990 and May 1991 and obtained a 90 per cent response rate. Their results showed:

"that most women (85 per cent) experienced at least one physical or psychological problem in hospital: 33 per cent experienced major complications such as bleeding or high blood pressure; 73 per cent complained of relatively minor problems such as tiredness, backache or

[342]Q420
[343]Q423
[344]Ev p 422
[345]Q727
[346]Q728
[347]Q729
[348]Q732
[349]Ev p115

constipation; and 87 per cent of all women required pain relief in hospital. At home, 87 per cent of mothers experienced at least one health problem: major problems such as bleeding or high blood pressure occurred in 46 per cent; and 78 per cent complained of relatively minor problems..."

and that

"42 per cent of women felt tired in hospital, and 32 per cent were unable to rest or sleep when required. When the baby was two months old, 59 per cent felt tired and 61 per cent were unable to get as much rest as they needed. 49 per cent felt that they were not coping well when they first went home, and 44 per cent still felt this way when their babies were 8 weeks old".[350]

This confirmed forcefully the suspicions of the RCM that lack of research reflected a lack of good practice in this important area.

246. The research in the Grampian again picked up the significance of continuity of care. One of the recommendations of the report was that:

"Thought should be given to reducing both the numbers of midwives and the variety of types of staff caring for an individual woman. This would facilitate co-ordination of care, improve continuity of care and reducing conflicting advice".[351]

247. This lies four-square with the conclusions we have already expressed earlier in this report, and we fully endorse the recommendation. However, the authors of the report identified many other detailed needs of women, and once again pointed to the negative effects of over-medicalisation of maternity care that has been one of the persistent themes of this inquiry. Their first conclusion was:

"Postnatal care has been neglected for too long. Despite considerable resources, many women and their families experience postnatal problems that are not addressed by the maternity services, which tend to take a narrow medical view of postnatal care".[352]

248. The report draws attention, like MacArthur et al[353] to the largely unacknowledged level of morbidity among mothers, concluding that ".. the popular model of a healthy, fit woman able to care for her baby is the exception. Most women are tired, in pain, physically unwell, depressed or unable to cope well'.[354] Their recommendations include the reorganisation of resources to free midwives to give more time to this aspect of care, the provision of maternity aides, privacy for mothers requiring postnatal care and more concentration on postnatal care in the community, without requiring mothers to attend hospitals. All these recommendations are in line with those made elsewhere in this report by us.

Lying-In

249. The need for postnatal care in the community can be exacerbated by the application of a rigid policy about the length of time for which women may remain in hospital after birth. The RCGP highlighted the need for mother's wishes about length of stay to be listened to and respected[355] as did the RCOG.[356] The Department's evidence indicated, somewhat surprisingly, that the average length of stay was 5 days (including labour) although they also said that 35 per cent of women stay for two days or less. They said, guardedly, with reference to the period of lying-in 'if possible her wishes will prevail'.[357] The RCM noted:

"The average length of stay in hospital of women in the postnatal period continues to decline. It is not clear to what extent this meets women's needs ... This is an important area of maternity care which requires some radical review to determine how women can best be offered practical support".[358]

250. All the groups involved in maternity care emphasised the need to ensure that mothers and babies were allowed to remain in contact in hospital, and that women were not subject to the imposition of rigid hospital routines and timetables which interfered in the mothers' ability to form

[350]MS428
[351]ibid
[352]MS428, para 38
[353]*Health After Childbirth*, MacArthur, Lewis and Knox, HMSO 1991
[354]MS428, para 14
[355]Ev p 220
[356]QQ 889-90
[357]Ev p 189
[358]Ev p126

a relationship with their baby at this critical time.[359] Interestingly, the Grampian survey confirmed[360] the anecdotal evidence which we collected on our visit to Wiltshire and Brecon in regard to the superior satisfaction about this aspect of their care of mothers using small maternity units compared to DGHs. **We concur with the RCM that the policy of reducing the length of lying-in for mothers in hospital merits very close examination in respect of its effect on maternal morbidity. We also recommend that the freedom of women to determine their length of stay, in consultation with midwives and doctors and within sensible limits, should be unequivocally stated by the Department of Health and promulgated to all hospitals.**

251. Length of stay is, once again, something about which individual mothers have differing views and needs. Many women want to get home very quickly, especially if they have good housing conditions and good support there. Others for a variety of reasons including poor housing, lack of support, or not feeling sufficiently recovered, may benefit from a longer stay.

Breastfeeding

252. The RCOG commented that:

> "The policy of early discharge into the community should be scientifically evaluated. Its effect on the successful establishment of breastfeeding, may ... be detrimental".[361]

253. Professor Alan Jackson, Head of the Department of nutrition at Southampton University wrote to us:

> "The evidence is overwhelming and conclusive that for all societies the infant who is fed by breast on the milk of its mother enjoys a measure of biological and maybe social advantage".[362]

and Professor Peter Howie sent us a copy of his paper from the BMJ[363] and expressed the view that breastfeeding has been given insufficient attention. He stated:

> "One of the important factors leading to the relative neglect has been the commonly perceived view that the advantages of breastfeeding over artificial feeding were marginal and that it was unnecessary to attempt to influence mothers' freedom of choice when it came to the method of feeding their infants".

He conducted a major investigation into the protective effect of breastfeeding against infection. He told us:

> "The findings showed unequivocally that babies who were breastfed for at least 13 weeks had between a 5 and 8-fold reduction in serious gastro-intestinal illness which persisted beyond the period of breastfeeding itself. This reduction in serious illness was reflected in a sharp reduction in hospital admissions due to vomiting and diarrhoea amongst babies who were breastfed for this length of time. There were also smaller reductions in respiratory infection amongst breastfed babies".

254. The establishment of the practice of breastfeeding was universally acknowledged as one of the key tasks for those who cared for mothers postnatally. The RCM emphasised in their evidence the training which midwives received in this aspect of care.[364] Their pre-eminence in this field was unchallenged by any witness. Needless to say, it was clear that this advice was much more likely to be well-received if it came from the same midwife who had already established a relationship with a mother in the antenatal and intrapartum periods.

255. On our visit to Sweden we received interesting evidence as to their success in changing attitudes to breastfeeding over the last decade or so. Breastfeeding is now the norm there. Whereas in the UK there seems a presumption that breastfeeding is difficult and women are likely to fail, in Sweden they have established that practically all mothers can breastfeed. This builds confidence and an expectation of success. This is reinforced by hospital practice, which forbids anything else by mouth without medical authorisation. The baby is put to the breast immediately after delivery. About 90 per cent of mothers are still breastfeeding after six weeks.[365] **We conclude that there is universal agreement between all involved in maternity care that an increase in the level of breastfeeding**

[359]Ev pp 98, 126, 188, 220, 261
[360]MS428, paras 21-24
[361]Ev p 379
[362]MS143
[363]MS296
[364]Ev p 125
[365]MS298

is desirable. We note that steps have been taken in some areas to focus upon developing this skill among midwives. We recommend that all midwife managers establish targets against which to measure the success of midwives in supporting breastfeeding among those women choosing to try to breastfeed their baby; that these targets should be challenging; and that the training and resources required to meet them be identified.

Conclusion

256. The RCM memorandum highlighted the wider social purposes of postnatal care. They believe that the service currently provided fails to meet modern needs:

> "... many women today have lives oriented towards work and the postnatal period can be a time of dislocation and loneliness. Others are under considerable economic pressure to return to work ... Women with new born babies are not infrequently isolated ... In many cultures, special care and attention is given to new mothers but in this country as a whole, not simply in the NHS, there is little clarity or consistency in the approach taken to women at this important time".[366]

257. **It is clear to us from the evidence of the professions that postnatal care, like other aspects of the maternity services, is poorly evaluated and researched, delivered in often inappropriate and fragmented ways and has a dissipated managerial focus which militates against efficient use of resources.** The costs of such neglect in maternal and infant morbidity and later need for the intervention of social workers, which could have been prevented by more timely and appropriate help, have not been calculated.

Special Care

258. Special care baby units (SCBUs) have been established in all but the smallest maternity hospitals for the management of babies who require observation and treatment falling short of intensive care, but exceeding normal routine care. We heard evidence that babies should not be admitted to SCBUs unless this is crucial for their well being and that wherever possible they should be looked after on the maternity wards by their mothers, with appropriate support. For example, the Neonatal Nurses Association wrote:

> "It is our considered opinion that healthy infants over 34 weeks' gestation should be nursed with their mothers. Low-dependency special care can be delivered at the bedside, for example: phototherapy, tube feeding, minimal clinical monitoring and intravenous cannulation for antibiotic therapy".[367]

259. Some hospitals have established transitional care nurseries as a "half-way house" between the SCBU and the maternity wards. One of the advantages of passing more responsibilities to midwives in this area would, of course, be to reinforce the element of continuity of care. Nonetheless, as we have repeatedly emphasised throughout this report, our principal focus of concern is not on what must be done when things go wrong and these backup services are called into action, but with the progress of the vast majority of normal pregnancies which produce healthy babies. **We conclude that the establishment of transitional care facilities within postnatal wards offers a very welcome development towards providing care in appropriate cases which resembles as closely as possible that provided for healthy babies.**

260. We asked Ms Hale of the Neonatal Nurses Association whether there are sufficient staff on postnatal wards for this transitional care. She told us that "The answer to that across the country is no. There are not enough midwives available to be able to give that slight extension of care which we feel should be within the normal role of the midwife to allow the baby to stay with his mother in the postnatal situation".[368]

261. Sir David Price summed up the problem, "So the picture we get .. which you might confirm or otherwise—is that there are some babies who are just a little bit under par but who should be nursed with their mothers and are sent instead to a higher level of care than they need, and there are other babies who need intensive care who cannot get it?" to which Ms Hale responded "That is right".[369]

[366]Ev p126
[367]Ev p 422
[368]Q1093
[369]Q1094

262. It seems clear that some of the problems associated with access into neonatal units which we discuss in the next chapter have the same roots as the difficulties experienced elsewhere in the maternity services. Failure to give emphasis in terms of resourcing and staffing to the primary levels of care, in this case the numbers of midwives on postnatal wards, has led to the meeting of some babies' clinical needs by a higher level of service than is indicated. **We recommend an urgent review of staffing and resources in postnatal wards, to ensure that babies needing transitional but not special or intensive care can remain with their mothers, be undertaken by all MSLCs in conjunction with the NNA, the RCM and the BAPM. Sufficient midwives should be made available to allow an increase in transitional care, thus releasing cots in neonatal units. We believe that the targeting of appropriate care to all three levels of neonatal need, whilst it may not entirely address the problem of insufficient intensive care facilities, can only help to relieve the problem.**

263. A few babies surviving after intensive and special care develop chronic problems affecting the lungs. We were impressed by the submission from Katherine Sleath, a nurse working in the Neonatal Unit at Hammersmith Hospital which showed that some of these babies could, with appropriate support, be discharged home earlier than was previously thought feasible. She wrote "At the end of one year, for all eight babies [discharged home], a total of 677 hospital days had been saved. All eight babies have survived with no long term delay in development and growth ... not one family regret having their baby home". She went on to demonstrate the cost-effectiveness of getting the babies home: "With an estimated cost of £150 per day in hospital, this is a total saving for all eight babies of £100,000 over the year."[370] We were also told of this development when we visited Queen Charlotte's Hospital, where it has been found to be beneficial.[371] **We recommend that sufficient provision of medical and nursing support in the community be made available so that the early discharge home of babies from special care units can be encouraged.**

CHAPTER IV: REGIONAL SERVICES

Introduction

264. The main emphasis of this report is that pregnancy and childbirth are normal processes, and should not be treated as illnesses. It must not be forgotten, though, that a major purpose of the maternity services is to ensure that the baby is given the best possible chance to achieve his or her full potential as a healthy, happy and productive member of society. When pregnancy or birth do not go normally then mothers and babies sometimes require highly skilled and highly specialised medical attention. These services are often provided in regional (tertiary) centres. We took evidence in this inquiry to see how the regional neonatal services and other regional services relating to maternity care were facing up to the reforms of the NHS.

Regional neonatal services

265. About 70 per cent of all perinatal mortality occurs in "low birthweight" babies (those weighing less than 2500 g) and about 50 per cent in those who are of "very low birthweight" (less than 1500 g). The low birthweight rate has been steady at around 7 per cent for over 20 years, although very recently there appears to have been a slight fall, and the number of very low birthweight babies born alive is increasing. Dr Patricia Hamilton, a consultant neonatologist at St George's Hospital, identified two of the main causes of this trend when she wrote:

> "... the number of babies requiring admission to intensive care Neonatal Units is rising.[372] This is partly because of increased expectations of survival for the extremely preterm and sick baby, but also because of the increasing success of fertility programmes ... we have to turn away many of these requests .."[373]

266. About three per cent of all infants born require *"intensive care"* if they are to survive. A further seven to nine percent require *"special care"*—observation and treatment falling short of intensive care, but exceeding normal routine care. We have discussed special care in the previous chapter. In some recent reports a third category of *"high dependency"* care has been interposed

[370]MS253
[371]MS238
[372]see figure 8
[373]MS328

between intensive and special care. Detailed definitions of what constitutes these three levels of care have been provided by the BPA and the BAPM,[374] the NNA[375] and the Royal College of Physicians (RCP).[376]

Intensive care

267. The major group of babies requiring intensive care are those of very low birthweight. Professor Eva Alberman wrote that:

> "The small proportion of births of very low birthweight contribute quite disproportionately to overall infant mortality ... They represent less than 1 per cent of all such births in England and Wales .. but 47 per cent of neonatal deaths and 30 per cent of all infant deaths".[377]

Neonatal intensive care is largely concerned with the care of VLBW infants although there are other substantial groups of infants requiring this care. Although the mortality rate of VLBW babies remains comparatively high, there have been improvements in their chances of survival in recent years. The absolute number of survivors weighing between 500 and 999g at birth increased by nearly 50 per cent between 1983 and 1987, and there was a 30 per cent increase overall in survivors weighing less than 1500g.[378] When we asked Professor Richard Cooke, President of the British Association of Perinatal Medicine what he thought was the balance between social and medical advances in achieving the reduction in perinatal mortality rate, he replied:

> "I think you have to look at which children are now alive which a decade ago were not alive, and they are mainly the very low birth weight children. There has also been a continued but smaller reduction in term deaths, although these are now at quite low levels, but the biggest change has been in the survival ... of very low birthweight infants and that seems to be related to the way that they are managed rather than anything else".[379]

268. Long-term follow-up studies of surviving VLBW infants have in general shown that the vast majority of survivors are normal children at school age. A major review of world-wide experience in developed countries showed that for liveborn VLBW babies the mortality rate had on average fallen from 72 per cent in 1960 to 27 per cent in 1985, and the proportion who had serious handicaps had remained stable at 5-10 per cent.[380] Dr Rivers quoted from the RCP report that:

> "It would appear that the results of intensive care for the newborn are better by any criteria than those obtained by the provision of life support to most other groups of patients".[381]

269. The improvement in outlook for VLBW babies and for other groups of ill or vulnerable babies has been widely attributed, in evidence presented to us, to the impact of modern methods of perinatal and neonatal care. Professor Peter Pharoah, Professor of Public Health in Liverpool, wrote:

> "Neonatology has been the most rapidly growing area of paediatrics over the decades of the 1970s and 1980s ... There is a considerable body of evidence that these services have led to a dramatic decline in mortality rates of low birthweight babies. Curiously, it is one of the few areas where it can be shown that an improvement in mortality rates is a direct result of medical services intervention".[382]

and the British Paediatric Association told us:

> "The results of perinatal care have improved greatly in the UK in the past decade, due to improved techniques, improved staff training and better organisation of provision of services on a national and regional basis".[383]

270. The report of the Expert Group on Special Care for Babies in 1971 recommended two types of neonatal unit, providing different levels of care. DGHs would all provide a comprehensive service for most mothers and their babies, who would if necessary be looked after in Special Care

[374]Ev p 434
[375]Ev p 414
[376]Medical Care of the Newborn in England and Wales, 1988
[377]MS341A
[378]Arch Did Child. 1991; 66: Q1304-1308; see figure 9
[379]Q1001
[380]Neonatal Intensive Care for Low Birthweight Infants: Costs and Effectiveness, Office of Technology Assessment, Washington DC, USA, 1987, Case Study 38
[381]Ev p 432
[382]MS151
[383]Ev p 412

Baby Units (SCBUs). Very frail or ill babies should be transferred to regional Neonatal Intensive Care Units (NICUs).

271. By 1978, when evidence was first taken for the inquiry which led to the Report from the Social Services Committee on Perinatal and Neonatal Mortality in 1980, most regions had formulated at least the elements of a regional strategy for the care of ill babies. The Social Services Committee recommended that

> "Every region should have one or two referral units which are equipped and staffed to provide the best possible intensive care for mother, fetus and newborn infant. These units should preferably be sited in major University centres and would be expected to care for the small minority of patients who have very serious problems. They would also be expected to fulfil a major role in teaching and research. These units should be called *regional perinatal centres*. Further, each region should designate a number of additional large maternity hospitals, perhaps three to five, as *sub-regional perinatal centres* where mothers and babies with problems that cannot be dealt with in every DGH can be cared for. Geographic factors should be carefully considered when designating the sub-regional centres, so that all pregnant women are within reasonable distance of one. Provision of neonatal intensive care cots should mainly be in the regional perinatal centres, but each sub- regional centre should have a number and the centres should be equipped and staffed accordingly. The staff of the NICUs of regional and sub-regional centres should be capable of transporting ill infants from other maternity hospitals".

> "All maternity hospitals not designated as regional or sub-regional centres should be supplied with facilities and staff for the provision of short-term intensive care. We recommend that local policies be worked out at regional level for the transfer, where appropriate, of mothers with high-risk pregnancies to the regional and sub-regional centres".[384]

It was also recommended that the regional perinatal centres should be the sites where all but the most complex neonatal surgery should be carried out.[385]

272. The recommendations of that Report were reinforced in two subsequent reports from the Social Services Committee[386] and were broadly accepted by the Government, provided suitable attention was paid to local factors.[387] In 1985 the MSAC endorsed the need for regional perinatal centres, but appeared to envisage that most or all DGHs would undertake intensive care. The establishment of a three tier structure as recommended by the Social Services Committee has been widely supported by the professions involved and it was in place or planned in twelve of the fourteen regions by 1988. In our current inquiry the Department told us

> "... both structures [two or three-tier] have much to commend them. Some Regions are basing their services on the three-tier structure recommended by the Social Services Committee. Others are closer to the two-tier structure proposed by the Maternity Services Advisory Committee. The Department believes that the pattern of provision must be that most appropriate for the area".[388]

273. Referring to the growing use of intensive care cots for multiple births, Professor Malcolm Levene of the British Association of Perinatal Medicine wrote:

> "Infertility centres should be in hospitals where there are adequately provisioned Neonatal Intensive Care Units. These Units should have enough capacity in terms of cots and equipment to be able to offer intensive care to 3, 4 or more [simultaneously born] babies at one time which will avoid the need to break up siblings ... and sending them to different hospitals for care".[389]

He went on to tell us in oral evidence:

> "We should be talking about perinatal care and the region I think should be planning for perinatal care which includes fetal medicine, perinatal pathology, neonatology and genetics, ... and I am quite sure that the region needs to have a strategic plan whereby there are relatively few numbers of perinatal centres to allow the cross-specialty care that is necessary ..."[390]

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[384]HC (79/-80) 633-I
[385]ibid
[386]HC (1983-84) 308, HC (1988-89) 54
[387]Cm 741
[388]Ev p 196
[389]Ev p 412
[390]Q1031

274. With regard to admissions of VLBW and ill babies to the NICUs of regional perinatal centres, we received a great deal of evidence that the units were often full, so that babies had to be turned away. Dr Jean Chapple of NW Thames RHA wrote:

> "We still do not have enough cots for all babies to be offered neonatal care when they need it, despite having relatively more intensive care facilities than the other Thames Regions. This situation is also likely to deteriorate with the more widespread use of surfactant, which increases survival of immature babies and therefore to longer stays in intensive care cots".[391]

And Dr Rivers stated:

> ".. an overall shortage of intensive care cots in the Thames and in other Regions ... has encouraged the haphazard development of IC cots in district maternity units, many of which do not come up to the minimum requirements for long term intensive care ... [which] requires a critical mass of staff and throughput ... Important consequences of these unfortunate developments have been a documented diminished survival rate for very low birthweight babies born in hospitals with either small NICUs or with special care baby units only, when compared with survival figures for those born or transferred to hospitals with larger NICUs".[392]

Dr Field and his colleagues in Leicester found that:

> "Infants of less than or equal to 28 weeks' gestation who received all their perinatal care in one of five large centres ... showed significantly better survival rates than infants treated ... at one of the 12 smaller units (34 survivors from 65 infants (52 per cent) compared with 8 survivors from 37 infants (22 per cent)".[393]

275. The Department does not collect information on the number of intensive care cots in England and Wales separately from special care cots. The RCP stated in its report[394] that in 1984 there were 473 intensive care cots in England and Wales and concluded that 983 were needed. There seems no doubt that the number of intensive care cots has increased since 1984, but clearly there are still not enough. Dr Iain Chalmers, Director of the National Perinatal Epidemiology Unit wrote:

> "A problem which is of particular relevance to neonatal care is the failure in published data [from the DH] to distinguish between special and intensive care when giving figures about cots, or places available in neonatal units. This is despite the fact that the Korner reports recommend how this distinction could be made".[395]

We conclude that it is manifestly wrong that ill babies requiring intensive care should be refused admission, or that twins or higher order births should have to be sent to different hospitals, because of lack of sufficient intensive care cots. We reiterate the recommendation of the Social Services Committee that data on the number and type of cots available and the number of and reasons for refusals of babies for care in them should be collected and that the correct level of provision be established and put in place.

276. We were pleased to learn that one of the first tasks to be undertaken by the Clinical Standards Advisory Group would be a study of access to regional units with particular reference to neonatal intensive care.[396] We hope that they will take account of the issues we have highlighted, and the recommendations we have made, in this report.

Related Regional Services

277. Dr Dian Donnai of the Regional Genetics Service in Manchester also stressed that a major component of genetic services should be organised at regional level, and required multidisciplinary staff,[397] and Dr Bernadette Modell, wrote:

> "From an operational point of view, genetics services must be provided at specialist and community level ... The specialists involved are clinical geneticists, and specialists in specific disorders, specialists in fetal medicine, neonatologists, paediatric pathologists and epidemiologists".[398]

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[391]Ev p 42
[392]Ev p 435
[393]MS306
[394]Medical Care of the Newborn in England and Wales, 1988
[395]MS50
[396]Hansard 16 January 1992, c627 w
[397]Ev p 50
[398]MS109

278. Dr C W G Redman, Reader in Obstetric Medicine, Oxford, argued strongly for the referral of women with high-risk pregnancies to tertiary [ie, regional] centres:

> "Tertiary centres are accepted for intensive care of the newborn and women are routinely transferred from one hospital to another when specialist neonatal care is required. But it is still a comparatively rare event that a woman is transferred for highly specialised obstetric care. Yet this is despite the fact that the last three Confidential Enquiries into Maternal Deaths have called for Regional Centres to cope with just one antenatal complication - severe preeclampsia/eclampsia".[399]

and Dr Wendy Savage, Senior Lecturer in Obstetrics and Gynaecology at the Royal London Hospital wrote:

> "There needs to be one or two centres in each region for sophisticated investigation by ultrasound and other invasive procedures such as amniocentesis, cordocentesis and CVS [chorion villus sampling] which require skilled technique".[400]

The College of Anaesthetists added its support for regionalisation of care for high-risk mothers and babies.[401] We believe this would be consistent with the broad approach outlined in this Report.

279. A number of witnesses emphasised the importance of the provision of a comprehensive regional service for perinatal pathology.[402] Professor Jonathan Wigglesworth, Professor of Perinatal Pathology at the Royal Postgraduate Medical School, in written evidence explained that perinatal pathology is mainly concerned with postmortem investigation of the fetus and infant. He stated that this procedure represented an important form of audit of a variety of aspects of human reproduction, by:

(a) Providing diagnosis of the cause or causes of fetal or perinatal death, or of abnormalities which caused the pregnancy to be terminated.

(b) Assessment of the accuracy of prenatal diagnostic techniques such as real time ultrasound.

(c) Expanding, and complementing, the gross observations of dysmorphology; thus aiding regional clinical geneticists.

(d) Recognition of unexpected hazards of new forms of investigation or treatment and providing a check on the ability of obstetricians and paediatricians to avoid known hazards of standard forms of treatment.

(e) Providing a basis for conducting audit into perinatal mortality at local or regional level, for recognising changing patterns of disease incidence and diagnosing new conditions.[403]

280. In oral evidence, Professor Wigglesworth emphasised the importance to the family of a correct pathological diagnosis. He pointed out that defining the exact cause of death in an adult may not always be of great significance:

> "... whereas in the perinatal period the precise diagnosis may be of critical importance for managing future pregnancies, for giving an assessment of the likelihood of a recurrence of this particular event".[404]

281. Both SATFA[405] and SANDS[406] emphasised the importance of parents being given the right to know why their babies died or were aborted, and therefore to have access to a report of a post-mortem with an appropriate professional present to explain its implications.

282. We learned from Professor Wigglesworth and Dr Ian Rushton, President of the British Paediatric Pathology Association, that perinatal pathology is a highly specialised field carried out by trained perinatal or paediatric pathologists,[407] and Dr Rushton provided us with evidence[408] from a survey that he had done that the general standard of perinatal autopsies, unless performed by an expert, was low.

283. In recent years it has become recognised that perinatal pathology should be organised as a regional service, and Professor Wigglesworth reminded us that:

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[399] MS132
[400] MS278
[401] MS235
[402] eg Q1266
[403] MS162
[404] Q1238
[405] MS44 para 5.12
[406] MS3A, para 4.5 (vii)
[407] Q1245
[408] MS374, 374A

"The need for regional specialists in perinatal pathology was recognised by the House of Commons Social Services Committee in their report on Perinatal and Neonatal Mortality in 1980. At that time it was suggested that there should be at least one specialist per region".[409]

This recommendation was reinforced in two subsequent report from the Committee.[410] In its reply to the 1988 report,[411] the Government accepted this recommendation and announced a major initiative to:

"try to find out more precisely why particular babies die".

One element of this initiative was the establishment of the Confidential Enquiry into Stillbirths and Neonatal Deaths which the Minister of Health announced on 2 July 1991. The reply continued:

"The NHS needs to increase its capacity to undertake expert postmortem examination of infants who die, and this is essential to the introduction of an effective Confidential Enquiry ... the Management Executive has been asked to ensure all Regions have at least one paediatric pathologist in post by April 1991 and that they have also conducted a review of needs with a view to establishing further posts that are required by 1992".

284. Professor Wigglesworth defined in evidence[412] the necessary components of a regionally based service for perinatal pathology in terms of the requirements for staff and equipment. He stated that a working party of the Royal College of Pathologists had suggested that 1.5-2 whole time equivalent consultants would be needed, supported by Medical Laboratory Scientific Officers.

285. The role of the regional unit is not just to conduct autopsies on complex cases, it is to provide back-up facilities for a range of investigations not available in every DGH, and also to provide guidance and training for general pathologists - as well as to conduct research and act as a focus for confidential enquiries and epidemiological surveys into perinatal death. Yet Professor Wigglesworth found from a survey (of the BPPA) that:

"... the regional perinatal pathology unit as envisaged by the Royal College of Pathology (RCPath) Working Party hardly yet exists".[413]

286. In its document "Confidential Enquiry into Stillbirths and Deaths in Infancy"[414] which announced the setting up of the enquiry, the Department showed that two regions, East Anglia and Trent, had no perinatal pathologists at all and most of the other regions were very poorly supported, mostly by part-time posts.[415] When we asked whether the perinatal pathology service would be able to cope with the work involved in the confidential enquiry, Professor Wigglesworth replied:

"... I think that most of us will find it fairly difficult to undertake additional responsibilities without additional assistance and, certainly, in the regions where there is no perinatal pathologist I do not see how they can possibly do it ..."[416]

We were very surprised when Dr Rushton went on:

"... the enquiry was announced and we, as pathologists, have not been approached about the enquiry and, also, when I attended a meeting of the British Association of Perinatal Medicine hoping that I would find out more about the enquiry, nobody seemed to know anything about it and I think that the problem is that the right people have not been approached and, certainly, we would have felt that if there were going to be another enquiry into perinatal mortality one of the groups which should have been approached was our own".

287. Although Professor Wigglesworth told us[417] that he thought further posts had recently been established **we conclude that little progress has been made in the establishment of a satisfactory regional service for perinatal pathology since the Social Services Committee made its first recommendations on the subject in 1980. We do not see how the Government's initiative to find out why particular babies die, can be carried out unless a proper service is in place. We recommend that an immediate survey be done to define the number of perinatal pathologists in post, that the necessary number be agreed between the Department and the professional bodies (the RCPath and the BPPA), and that this number be established as soon as possible.**

[409]MS161
[410]HC (1983-84) 308, para 60; HC (1988-89) 54, para 24
[411]Cm 741
[412]MS161
[413]MS161
[414]op cit, DH 1990
[415]ibid, Annex D
[416]Q1278
[417]Q1266

Disability and follow-up

288. We have quoted evidence earlier that a large majority of surviving VLBW infants, who form the major workload of neonatal intensive care units, prove later to be normal children.[418] However, a significant minority have impairments, sometimes disabling, such as cerebral palsy, and deficits of vision and hearing. We have received evidence from some parts of the UK that the proportion of VLBW infants who survive but have disabilities is increasing. This may be a price that has to be paid for the much larger increase in the proportion surviving, but it is nevertheless a worrying trend. Drs Johnson, Morley and Mutch provided evidence that the risk of cerebral palsy increased with decreasing gestation or birthweight to about 1 in 20 in infants weighing less than 1000g and that as many as 1 in 5 might have a serious impairment of some sort.[419]

289. The rate of disability in VLBW intensive care survivors must be kept in proportion. Professor Alberman has estimated that VLBW infants contribute only about 2 per cent to the total number of seriously disabled children in the community.[420] By far the largest contributor (73 per cent) was children with congenital abnormalities such as Down's syndrome, who almost always survive without intensive care. She thought that birth asphyxia contributed about 5 per cent, and most of the remainder were of unknown cause.[421] Evidence consistent with Professor Alberman's estimates is to be found in the submission from the Oxford Region Child Development Project:

> "For children born in 1984 and 1985 the birth cohort rates of cerebral palsy, severe vision impairment and sensorineural deafness were 2.0, 1.1. and 1.0/1000 live- births respectively".[422]

It was further shown that most of the impaired children weighed at least 2000g at birth (and therefore would mostly not have received intensive care):

> "Although the risk of these impairments increased with decreasing birthweight, only 20 per cent of the children on the register weighed under 2000g at birth".[423]

290. Although the contribution of intensive care survivors to childhood disability is small, numerous witnesses have emphasised the importance of following up the infants at least to school age, for reasons of audit, and also so that any impairment may be identified early and if possible remedied.[424] Also, VLBW survivors with normal Intelligence Quotients often show subtle learning difficulties in school and require special attention.[425] **We recommend that geographically-based follow-up of intensive-care survivors, especially VLBW infants, should be regionally organised and supervised by Regional Perinatal Advisory Committees. The results should be made widely available so that the outcome of intensive care is clearly known.**

Impact of the NHS Reforms

291. The Committee heard evidence that the NHS reforms might put at risk regional services for perinatal and neonatal intensive care, and for other relevant specialties including genetic services and perinatal pathology. Dr Andrew Meeks, Consultant Neonatologist at the Royal Sussex County Hospital in Brighton wrote:

> "The latest reforms, ... will lead to a devolution of neonatal intensive care units to district level. Often units do not have the medical or nursing expertise to care for such sick infants. It is a sad fact that it is much cheaper to make a token gesture of intensive care in your own unit and the baby die in the early days than to be transferred to a major unit where, with more expert and intensive care continued for a longer period, the child could have a chance of survival. Perhaps more importantly, it is very difficult to measure outcome as the babies need to be followed up well into childhood".[426]

Dr Gamsu wrote:

> "The prospect of far-reaching changes in the organisation of health care ... fills me with misgivings. Even more so, when I see that a number of small units in district hospitals are hoping to provide intensive care themselves, rather than send babies to appropriate regional

[418]Para 268 of this report
[419]MS176
[420]Alberman E.D. The epidemiology of congenital defects: a pragmatic approach. Adinolfi M. et al (eds) Paediatric Research: A Genetic Approach, London, Heinemann, pp 1-28, 1982
[421]ibid & Q1382
[422]MS188
[423]ibid
[424]MS 151, 171, 176, 322 and 325
[425]MS438
[426]MS315

units, ... Some regions such as our own are about to abrogate any responsibility for neonatal care and have promoted the idea that it should become a district responsibility, thus creating a free-for-all for local entrepreneurs...".

He went on:

"There is however enough data well known to your Committee from its previous deliberations[427] to justify the necessary provision of neonatal intensive care in designated units organised regionally, audited regionally and funded regionally. Slow progress was being made towards reaching this objective and this progress looks as though it is about to be halted".[428]

292. Dr Rivers wrote:

"The possibility of each district maternity hospital deciding to go it alone and set up neonatal intensive care 'because we could do it cheaper' than the regional or subregional centres by utilising suboptimal establishments ... becomes a real danger for babies ... at present no authority has the power to stop a unit providing an inadequate form of intensive care no matter what the outcome data might reveal".[429]

And Dr Kate Costeloe, Consultant Neonatal Paediatrician at Homerton Hospital stated her view that "... it is impossible to be confident about what might happen post-April 1992".[430] When we questioned representatives of the BAPM, British Paediatric Association, Neonatal Nurses Association and the Thames Regional Perinatal Group about their views on the effects of the reforms on regional services for ill babies and their mothers, all affirmed their anxiety that these services were under threat.[431] For example, Professor Hull, President of the British Paediatric Association said "...it is not at all clear to us just what is going to happen in future because nobody is responsible any more for tertiary services in anything, never mind neonatal medicine"[432] and the BAPM told us that, following the reforms, Trust hospitals might, for financial reasons, introduce expensive and unproven therapies.[433]

293. A number of witnesses told us that under the new arrangements, a flat-rate charge is made to the district of residence for the admission of an ill baby to an intensive care unit.[434] For example, Dr Rivers said that " ... it is a flat rate of payment so that if the level three [regional] unit ... is faced with three months of intensive care, it gets exactly the same amount as a unit accepting babies for two or three days in intensive care".[435] And Professor Cooke said, with reference to the decision about charging made by the accountants at his regional unit:

"They felt that a simple block contract based on £8000 per case was the cheapest and easiest way of doing it. They are still looking at the possibility of going for cost for volume but until there is any form of computerisation in place that is virtually an impossibility".[436]

294. Rather than charge a flat rate for admissions, a more sensitive system would be to charge for the actual work done, as indicated by the number of days spent at each level of care. Although Professor Levene stated that "... it is very costly actually to get the data .." there are places where, at the end of each day, a senior nurse or other qualified person assigns each baby to the appropriate level of care as a basis for billing, by using definitions of intensive, high-dependency and special care formulated by the professional bodies and which are readily available. This procedure does not apparently require any complicated computing and is straightforward to carry out.[437]

295. In view of all the perceived problems that have arisen for neonatal services in association with the NHS reforms, we asked Dr Walford whether regional perinatal centres "... could fold because of the contracting hassles that could well result ...?"[438] She was unable to give a clear response. When pressed as to whether regions could force DHAs to make appropriate contracts, she responded "No".[439] We then asked her[440] for a note on the contractual arrangements being

[427]NB Of the Social Services Committee
[428]MS316
[429]Ev p 436 ff
[430]MS171
[431]Q1000 ff
[432]Q1022
[433]Q1053-1055
[434]eg Q1024
[435]Q1023
[436]Q1049
[437]Regional Guidelines for Service Contracts. Neonatal care services. NETRHA 1991.
[438]Q578
[439]Q579
[440]Q 582

made to fund the regional perinatal and neonatal intensive care services. This note[441] reveals that only two Regions appear to be placing regional contracts. All the others are devolving decisions to District level, though some Regions are trying to apply pressure to ensure that the service continues.

296. We later asked the Minister for Health, Mrs Bottomley:

> "... what problems, if any, have arisen in the operation of contracts for maternity services between purchasers and providers? How are cross-boundary referrals for specialist services (antenatally or for neonatal care) being organised? Are admissions to neonatal centres "extracontractual referrals" and if so, is there a guarantee that the parent health authority will always agree to pay the bills?"

She replied "This is an area that has not caused difficulties"[442] and invited Mr Edwards, Regional General Manager of the Trent region to comment on the way the service was working in his region. He replied, with reference to neonatal intensive care:

> "We have not had any financial barriers put in the way thus far, I do not expect that we would. These are very ill babies and we would normally expect the professionals to get on with it and we will sweep up after them".[443]

297. Mr Edwards was then asked whether it was correct[444] that the neonatal services are being charged for at a flat rate, to which he replied:

> "There is not, I do not think, a uniform national position on this currently. In my own particular region the services are contracted for regionally on the basis of an agreed sum which is top sliced and allocated. This is the pattern across most of the country. In some parts of the country the specialties are handled at the level of the district, in most parts they are handled at the level of the region and in that respect they are a free good".

However, this statement appeared to contradict written evidence from the DH[445] and Dr Walford disagreed with Mr Edwards, stating that "... only a few regions now themselves have a block contract with the unit".[446]

298. Although there appeared to be some confusion about the current arrangements for the funding of regional perinatal services, Dr Walford told us that:

> "The three-tier service is a regional highly specialised service ... We have no plans to change that arrangement, we believe certain babies must go to specialised units and it would be quite wrong for that district to try to duplicate those services at that level".[447]

299. We asked Dr Walford whether a scheme of accreditation of neonatal intensive care units should be introduced to prevent small units trying their hand on the grounds that they may be able to do it more cheaply. She replied "Purchasers have a responsibility not to purchase care that is not of the standard required"[448] and later added "A system of accreditation is not in contemplation and is quite likely to be unnecessary in this area".[449]

300. The Minister of Health and Dr Walford[450] both thought that audit would guide contracts, and hence accreditation would be unnecessary. But audit in perinatal medicine is a very difficult matter. Perinatal mortality rates are very sensitive to the attitude taken locally to the registration of very immature babies[451] and long-term follow-up is required before disability rates can be calculated. While we acknowledge that the reforms are only 10 months old, we believe it is vital to preserve the advances made in regional services. **We are not persuaded that the establishment of contracts for regional services for perinatal and neonatal intensive care can be left to market forces and audit.**

301. In response to written questions from the Committee about the current state of contracts for neonatal care, the Department amplified some of the remarks made earlier by witnesses,[452] but

[441] Ev p 342 ff
[442] Q858
[443] Q858
[444] Q859
[445] Ev p 342 ff
[446] Q862
[447] Q864
[448] Q865
[449] Q866
[450] ibid
[451] Q1356
[452] Ev p 363

it seemed plain from this document that no central guidelines are in place for ensuring the maintenance of the highly specialised regional services for perinatal and neonatal intensive care, and that regions and districts are responding to the reforms in a variety of different ways. The Department told us that "Accreditation of national minimum standards runs the risk of ensuring that the minimum standards are the only standards people bother with" and that they did not expect to review their position.[453]

302. **We think this view is mistaken. Guidelines which could be flexibly applied are available for the staffing and equipment levels needed to run NICUs in regional perinatal centres and in subregional centres.**[454] In view of the concerns expressed to us by many of those directly involved in the provision of these services, and challenged only by the Department of Health, it would appear that some form of accreditation of these units, which could be granted by Regional Perinatal Advisory Committees in consultation with the relevant professional bodies, would have advantages. In particular, it would prevent small units from attempting to undertake intensive care without proper staff, expertise and facilities. Some such form of accreditation could be used to underpin the contracting process in the early years of the reforms. **In order to safeguard regional perinatal and neonatal services, we therefore recommend:**

- **the establishment of Regional Perinatal Advisory Committees (RPACs) to plan and supervise the regional services.**
- **Regional contracts, if possible, or failing that district contracts that be placed only in units accredited by the RPACs, and which are sensitive to the work actually done.**
- **Freedom should be retained for mothers whose babies in utero are at very high risk and for babies requiring intensive care to be treated as emergency extracontractual referrals.**

303. Professor Wigglesworth believed that[455] the effects of the NHS reforms on the regional services for perinatal pathology would:

> "... inevitably have a deleterious effect on the provision of the service unless special arrangements are made to protect it".

He pointed out that the cost of a perinatal autopsy was about £300-£400 but could be as high as £600 or more if special tests were required, and went on:

> "Any purchaser of services faced with such a cost is likely to query the need for examination or to suggest that it be performed by the local district general hospital at a lower price ... there will be pressure on perinatal pathologists to abandon their time-consuming and uneconomic work on dead fetuses and neonates in favour of surgical pathology, cytology, etc, which are low cost, high turnover activities".

We recommend that, in order to ensure the success of the Confidential Inquiry into Stillbirths and Neonatal Deaths, means must be found for preserving the funding of regional services for perinatal pathology where these exist, and funds provided for setting them up where they do not. We are again concerned that such highly specialised provision should be left solely to the operation of the internal market at this very early stage of its introduction, and we recommend a system of top-sliced funding to ensure the creation of an effective perinatal and paediatric pathology service.

Conclusion

304. We are persuaded by the evidence we have received in this inquiry that the overall success of local maternity services is dependent upon the effective maintenance of regional centres of excellence, not only in perinatal and neonatal intensive care but in other related specialties. This does not preclude the development of other centres of excellence elsewhere where appropriate, and later in this report we will discuss ways in which the future of the maternity services should be examined and mechanisms for establishing health care targets. It would be appropriate for the regional services to be considered in that context, for as we have stressed, the maternity services should be considered as a whole. **At present reforms of the NHS are being put into effect which may have far-reaching consequences on its organisation and structure. We believe that it is vital to ensure that, during this period of change, the regional specialties are protected.**

[453]Ev p 364
[454]Ev p. 415 ff
[455]MS161

CHAPTER V: THE MATERNITY SERVICES OF THE FUTURE

Introduction

305. The evidence that we have received in the course of this inquiry has persuaded us that the philosophy of approach to maternity care that is most characteristically summarised in the phrase 'no birth is normal except in retrospect'[456] has been and continues to be an impediment to the delivery of a style and pattern of maternity care that will meet the expressed wishes of the majority of women who use these services. The exclusive concentration on this particular aspect of the risks of birth has sometimes been used as a rationalisation for a process whereby women increasingly feel excluded from control over the type of care they receive during pregnancy and childbirth and feel increasingly treated as passive recipients of an imposed and unexplained series of interventions 'on their behalf' and not as active partners in the birth of their own children. These are the predominant themes which emerged from our analysis of the evidence presented to this inquiry by women and their representatives. These problems were widely, though not uniformly, acknowledged by the professionals involved in the delivery of maternity services. There was broad agreement that women need better continuity of care and carer, more choice and control over their pregnancies and the birth of their children, more information about the options available to them, and more support after the birth of their children.

A new philosophy

306. Although home births now represent a tiny proportion of confinements in this country, we believe that the prominence of the debate on this issue is a result not of the demands of a vociferous and unrepresentative minority, but of a perception that the home is an ideal setting in which to satisfy the aspirations of women. The debate about home births brings into their sharpest focus the key issues which lie at the heart of the widespread dissatisfaction with what is currently provided by the maternity services. We have no evidence on which to base any reliable assessment of how many women would choose home confinements if their choice was unconstrained, but we are persuaded that it would almost certainly be a substantially higher proportion than at present. Nor, for reasons which we will examine in more detail later, does it appear to us that there exists at present a reliable way to measure precisely the impact of any pattern of maternity care on maternal, perinatal and infant mortality and morbidity.

307. We do not suggest that the admirable record of achievement in these fields should be disregarded, or that the *proven* advantages of advances in medical care during and immediately after pregnancy and childbirth should be abandoned. We must continue to give attention to how to achieve better care for mothers and babies in all contexts. But policy should not be driven by the illusion that we can abolish death. Whether or not PNM rates have reached or are approaching an irreducible minimum we do not presume to judge. We would however point out that a significant improvement in the perinatal mortality rate would be achieved if the lowest social class PNM rate could be improved to the level of the highest social class, and if the worst geographical areas could achieve the figures of the best.[457] These are not related to levels of concentration of births in large district general hospitals, nor to the increased use of high technology in the birth process, since both these are at high levels everywhere. They are far more likely to be susceptible to other forms of social advance and support for mothers. We indicate some of these elsewhere in this report. **We certainly concur with the Minister of Health[458] that the time has come for a shift in emphasis in the development of policy for the maternity services which gives due weight to other criteria for success additional to the reduction of perinatal mortality. To achieve that shift in emphasis will, we believe, require energy, determination and leadership at all levels of the National Health Service and within the Department of Health, as well as among the representative institutions of the professions involved in the maternity services, to enable them to assess and then to meet the widely expressed wishes of women and their families for a different approach. It will not come about by mere wishing.** It will be appropriate in that context to consider whether the incremental costs of further reductions in an already very low perinatal mortality rate can be justified were they to result in a demonstrable negative effect on the kind of care received by the majority of mothers and babies. Physical morbidity and mental trauma in new mothers have not received sufficient attention, yet they are extremely important for the sake of those women and for the health and well-being of their babies.

[456]Q831
[457]see figures 10, 11 and 12
[458]Q1516

308. The delivery of maternity services has all too frequently been considered in a rather fragmented way. The antenatal, intranatal and postnatal periods have often been seen as distinct and rather separate components of the process of childbirth, and this has tended to mitigate against the development of an overall coherent, woman-centred approach to her care. By viewing maternity care in a more holistic way much of the dissatisfaction with the present system of maternity care could be overcome. A number of different professional groups are involved with the delivery of maternity care and we have received much evidence to indicate that this frequently results in a duplication and inappropriate use of resources. The RCM indicated four flaws in the system:

> "It assumes a pathological approach to pregnancy, the validity of which is contrary to the evidence. 80 per cent of pregnancies are normal and end in a normal delivery at which the midwife is the senior person present.
>
> It confuses responsibilities.
>
> It increases costs.
>
> It limits choice for women".[459]

309. We have concluded from the evidence presented to this inquiry that the present pattern of 'shared care' for women is failing to meet their needs. It has developed in such a way as to provide a fragmented, sometimes inefficient and rigid pattern of care often more determined by the needs of the professions, the unimaginativeness of managers and the self-validating arguments drawn from current prejudices about the division of labour than the wishes of women. **We recommend a radical reappraisal of the current system of shared care with a presumption in favour of its abandonment.** Rather than focusing attention on the providers of care and on the different types of services they provide, it should be the characteristics of the mother herself which should determine the planning of the service she is provided with. There is much evidence to support the view that women require their care to be readily accessible and to be provided by a health professional with whom they have been able to form a relationship and who will be with them during the birth of their baby as well as antenatally and postnatally.

310. An important factor in making this type of care successful is the flexibility of the midwifery input - so that the midwife is able to work in both the hospital and in the community and can be wherever the woman needs her. With this type of care for low-risk pregnancies there will be a minimum amount of involvement from an obstetrician during normal pregnancies, that care being reserved for those women who need specific obstetric input thus giving obstetricians more time to devote their valuable skills to treating such women. In the best schemes described, midwives have a close working relationship with GPs in their area and women continue to see their GP during the pregnancy, to enhance their relationship with the person responsible for their general care and that of their family both before and after the baby is born. Midwives and GPs have in these places developed a complementary system of working that uses the skills of each without duplication of effort.

GP maternity units

311. The service provided by GP Maternity Units, whether in rural 'cottage hospitals' or urban settings provides a model of care which, we are persuaded by the evidence we have received, offers a service for many women who are in low-risk categories and experiencing normal pregnancies which approaches more nearly the ideal that we have already described. It also offers a compromise between delivery in a consultant obstetric unit and at home which appeals to many women who are anxious about the risks (whether illusory or otherwise) of home births. While we acknowledge the sincerely expressed anxieties of paediatricians about the impact of births in such units on PNM rates, there is no conclusive evidence on safety which could possibly justify their wholesale closure. If it is shown that an avoidable death has occurred in any such unit, the lessons should be learned and acted upon. But we do not close rural roads because the accident statistics for them are worse than motorways, and there are many other areas of public policy in which risk must be balanced against gain. The purported risk of birth in a peripheral maternity unit is not proven. Nor has any sensible attempt that we are aware of been made to assess the different risks associated with DGH maternity units in terms of morbidity and a reduction in maternal satisfaction, let alone mortality.

312. Nor, as we have already discussed earlier, has it been shown that maintaining such units is necessarily more expensive than wholesale centralisation. No effort is made in such calculations to include the costs to mothers and their families in time, fares and petrol of centralisation. No value

[459]Ev p119, para 2.2

is given to the very real benefit of families being able to be together at this crucial period. Additionally, as the Minister pointed out, the cost of these units depends crucially on throughput,[460] and that has been very heavily influenced by medical pressure from both GPs and other professionals on women to use DGH facilities, often arising from a misconception on their part of the perceived risks.[461] The deskilling of GPs and midwives in intrapartum care and the consequent loss of confidence of which we have heard has also, we believe, played a part.[462] Our visit to Bath HA showed that the under-utilisation of such units need not happen where there is a culture which supports them and where the leadership from the centre acknowledges their advantages in meeting women's wishes. **We therefore recommend that the policy of closing such units on presumptive grounds of safety be abandoned forthwith. We further recommend that no decision be taken to close such a unit unless it can be explicitly and incontrovertibly demonstrated that they are failing to provide value for money, and that the costs to consumers are fully taken into account in making such calculations. We recommend that in considering any appeal against the closure of such a unit, the Secretary of State should make a presumption against closure unless the case is overwhelming, since we believe that there is a shift in attitude towards maternity care which can only be met by maintaining such units as a realistically available option.**

313. We are not convinced by the evidence that we have heard that the decisions about the future of such units have in the past been always soundly based. Indeed, we believe they have often been made on the basis of assumptions about safety and costs which now appear to be unsustainable. We believe that it is an urgent priority to re-evaluate the safety of, costs of and consumer satisfaction provided by, rural peripheral maternity units. We note that the Bath HA is uniquely positioned to be the focus of such research since it currently delivers 30 per cent of its babies in such units,[463] the largest proportion, so far as we can ascertain, in this country. **We therefore recommend that a study be funded by the Department to consider all aspects of the work of these units in the Bath HA, and that it be designed not only to reassess the issues of safety and cost, but also to take account of the other criteria we have identified in this report for defining success in the delivery of maternity care.**

Backup services

314. If women want to give birth at home, or in community units not attached to a district general hospital with ready access to blood transfusion and other emergency facilities, then emergency arrangements must be available to cope with the unpredictable need for resuscitation of the mother or baby.

315. The Royal College of Midwives feels that:

> "there should be a resuscitation service of people with the right expertise. I think we see the development of an emergency resuscitative unit which utilises both the ambulance service and medical people, not just ambulance people".[464]

316. Medical professionals however resist the idea of staffing an emergency service with medical personnel. The traditional "flying squad" consists of a midwife, an obstetrician, a paediatrician and an anaesthetist. It is now the official policy of the Royal College of Obstetricians and Gynaecologists that such squads be replaced by a paramedical team of ambulance personnel with extended training.[465] This is because flying squads leave what is often a busy labour ward, with high risk women in labour, denuded of experienced medical staff.

317. A survey of 55 Thames regions obstetric units in 1988 showed that in over a third of cases, dispatching a flying squad left the labour ward with only a senior house officer in charge, who would be incapable of dealing with a serious emergency arising in the hospital labour ward.[466] A recent review of flying squad calls from St Thomas's Hospital in London found that it took on average 28 minutes for the team to be assembled and arrive at the mother's home, whereas she could have been transferred directly from home to hospital by ambulance in an average of ten minutes.[467] The conclusions of the study were that sending a flying squad was:

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[460]Q1523

[461]Q1478

[462]see Chapter III

[463]Q1528

[464]Q406

[465]The future of emergency domiciliary obstetric services ('flying squads') RCOG April 1990

[466]The Flying Squad (November 1991) Leading article in the British Journal of Obstetrics and Gynaecology, **98** 1067-1069

[467]The flying squad - an expensive and potentially dangerous practice in modern obstetrics. Trehan AK and Fergusson ILC, British Journal of Obstetrics and Gynaecology **98** 1177-1179

"an expensive and potentially hazardous practice which should be abandoned".

318. The arrangement preferred by the medical profession is the provision of ambulances staffed with paramedics who are sufficiently trained in resuscitation to ensure the safest possible transfer of mothers and babies to units where skilled medical attention is available. We have been informed that a national training programme for extended training in ambulance aid, emergency obstetrics and gynaecology has been produced by the NHS Training Authority. **We recommend the development of such paramedic training and the provision of appropriately equipped ambulances in all areas.** In hospitals, paediatric staff are responsible for the resuscitation of babies which fail to breathe at birth. For babies born at home, or in small units, even if selected on the basis of low risk, a small minority will fail to breathe. If midwives and GPs are to have fully developed skills to ensure their resuscitation, this will have implications for their training which we discuss in the next chapter. **We recommend that MSLCs should be required to develop effective emergency arrangements for the resuscitation of mothers and babies in all areas.**

319. If more of the care is to be devolved in the community there will also need to be a rapid referral system available both to the midwives and the General Practitioners to avail themselves of the specialist advice and investigations if required. The development of a community-based maternity service will, we believe, require a cultural shift within the obstetric specialty to a new orientation away from demanding that women go to obstetricians and a willingness among obstetricians to go to women. To the extent that obstetricians are wedded to a medical model of care, they must be encouraged to be open to an alternative model. Some witnesses have suggested that the obstetric specialty should have no role in a normal pregnancy. We are not convinced that this is what women want, nor are we persuaded that it would be appropriate.

Midwife-managed units

320. GP Maternity Units in rural areas provide a pattern of care that many women find appropriate, and which can also provide a happy compromise combining many of the advantages of a home birth with the security that some women wish and some need of a hospital environment. We have been impressed by the evidence we have received of the successful introduction of midwife-managed maternity units. We received evidence from Leicester Royal Infirmary and Aberdeen Maternity Hospital regarding the development of midwifery units. In both centres, midwives provide intrapartum care to all normal women booked for delivery in midwifery units, but in Leicester midwives also provide antenatal and postnatal care. In both centres the units are sited adjacent to the specialist units. Women who develop problems can be transferred immediately; and have the full range of services available, with continuity of care by the same midwife.

321. Two midwives, June Kennedy and Margaret Hopkins, wrote "the scheme gives greater choice and satisfaction to both mothers and midwives" and it "shows no increase in either maternal or perinatal mortality and morbidity". Their research showed that 54 per cent of women initially booked for delivery in the unit required transfer to specialist units, because of complications arising either antenatally or in labour.

322. The midwifery unit in Aberdeen has been established since April 1990. In the first year the transfer rate in labour was nearly 20 per cent. Miss Joan Milne, Clinical Midwifery Manager wrote "The unit is an important part of facilities which should be available for women" and that:

> "The unit has been well received by Consultant Staff and midwifery staff are delighted with the concept. They feel they can practice their range of skills effectively and independently, with a safe environment and with back-up from medical colleagues where required".

323. We believe that the evidence from these two units suggests to us that development of such midwifery units adjacent to specialist units should be encouraged. The development of these units in urban areas could meet many of the requirements that we have identified to make real choice available to women. It is important to stress that these units do not simply represent an extension of the laudable efforts that have been made to humanise the environment of maternity units in DGHs. They represent, if fully realised, the choice of a pattern of maternity care which moves away from the high risk, high anxiety model that many women feel they are drawn into against their better judgement.

324. Where such units are combined with a properly effective continuity of midwifery care working both in the hospital and in the community, as we saw in the Riverside Health Authority and the Rhondda, then we believe that they may well point the way forward to providing for women in urban areas a real choice that lies between home confinement and the consultant obstetric unit. They will also enable midwives to achieve that degree of autonomy which we believe

is a key element in enabling them to shoulder the increased responsibility which we have identified as appropriate. **We recommend that the development of midwifery-managed maternity units, combined with effective continuity of midwife care between the community and hospital, should be pursued by all DHAs.**

Consultant units

325. We have no doubt that a substantial proportion of women will continue to choose, and a substantial proportion will be advised because of risk factors, to have their babies delivered in consultant obstetric units with the ready availability of skilled medical assistance and the full range of emergency services which are there available. The extent to which that choice might be constrained, and indeed, to which the choice of a home birth or low-tech unit might be constrained is, we believe, an appropriate matter to be resolved within local protocols developed by MSLCs, preferably established within overall national guidelines. We saw an example of how this works in practice on our visit to the Netherlands, where the well-known 'Kloostermans list' system is in operation. We also had the opportunity of talking to the author of this list, Dr Kloostermans himself. A variant of this system is used within the Bath Health Authority for the same purpose. While we heard arguments in both places that such systems of dividing pregnant women into risk categories and allocating them to different places of delivery and styles of care to an extent restricted individual choice, it was also apparent to us that *real* choice still existed in both places because different styles of care were maintained by policies which encouraged women to choose a style of care appropriate to their needs. As we have already stated more than once, there is little evidence of real choice in England as a whole. As long as the focus remains an informed choice, we are persuaded that such protocols can work effectively to maintain it. The key to providing effective choice is the effective provision of information about appropriate care, risks and benefits.

326. As we have already said, the importance of that choice is not whether there are wallpaper and curtains in the labour ward and beanbags and birthing pools in the delivery suites, but whether it represents a choice between different philosophies of maternity care. However, it would be unfair of us to publish this report without acknowledging the steps which have been taken to humanise the environment of maternity units in many acute hospitals. We were struck by the atmosphere of calm and the evidence of the choice available to mothers in the East Glamorgan General Hospital when we visited it. We have heard, however, many complaints about how while capital expenditure can, with difficulty, be secured for such improvements, the recurrent expenditure needed to maintain such facilities can be forgotten about by managers. **We recommend that all hospitals (including Trusts) write into their expenditure programmes sufficient funds to continue the process of humanising and maintaining in good condition their maternity units.** And we take this opportunity to remind those responsible of the requirements necessary to make such units begin to approach the model represented by the home.

327. It is clear that many women find it beneficial to be free to adopt whatever position feels right during labour and birth and a growing number find birthing pools helpful in labour and/or delivery. **We recommend that all hospitals make it their policy to make full provision whenever possible for women to choose the position which they prefer for labour and birth with the option of a birthing pool where this is practicable.**

328. The environment in which a woman gives birth is very important. If the home setting is considered as the model on which to base care, **a hospital delivery unit should**

- **afford privacy**
- **look like a normal room rather than be reminiscent of an operating theatre**
- **enable refreshments to be available for the woman and her partner or companions**
- **ensure the feasibility of the woman being "in control" of her labour. All case notes should contain the woman's wishes for her labour**
- **enable the woman to take up those positions in which she is most comfortable**
- **enable the woman to have with her a midwife she has been able to form a relationship with during her pregnancy.**

Ill babies

329. As we have seen earlier, up to 10 per cent of babies need to be admitted to a neonatal intensive or special care unit. This can be very stressful for parents and NICUs in particular are very intimidating places. We heard from the NNA[468] about the vital importance of involving parents as much as possible in the care of their infants.

330. **We recommend that neonatal units should be designed with the needs of parents and staff, as well as babies, in mind; and that accommodation should be provided for parents to live-in when required. Mothers of babies transferred from other hospitals should be moved as soon as feasible to the hospital treating their baby. Maximum support for all parents and family members should be available from doctors, nurses, religious and other counsellors and all those who work in the unit.**

Northern Ireland

331. We believe it would be appropriate at this point in our report to consider briefly the situation in Northern Ireland. The Committee visited Northern Ireland in June 1991 and had the opportunity to speak with staff from the Royal Maternity Hospital, the Jubilee Maternity Hospital and the Shankill Health centre. In preparation for the visit we received a memorandum on the maternity services from the Department of Health and Social Services,[469] a memorandum on the organisation and management of health and personal social services in Northern Ireland[470] and the 1991-92 HPSS Management Plan.[471]

332. We were very impressed with some of the local initiatives that had been developed in the community with particular focus upon preventative services to young people. The concept of targeting of services with appropriately designed programmes of antenatal and postnatal care to teenagers, first time mothers, single mothers and at risk mothers is one that might be usefully adopted elsewhere. We also heard of a scheme attempting to maximise peer group support to ensure the health education message reaches women and teenage girls who do not use the more formal health care settings.

333. On our visit to the Jubilee Hospital, Professor Nevin informed us of the higher rate of congenital malformations in the Northern Ireland population. Although there is no clearly identifiable reason why this should be so, he suggested that this could be as the result of an underlying genetic disorder, the fact that there is a higher proportion of older mothers in the Province and that the Abortion Act does not extend to Northern Ireland.

334. While on our visit we were most anxious to hear the extent to which the services offered a range of choices to women of the province. We asked Professor Thompson whether a Domino Scheme was available but were informed that although the system had been considered, the consultants were concerned that it might give some women a preferential service and GPs are not sufficiently interested so that the service had not been introduced. We were unable to question the midwives at this hospital; and we were additionally surprised to find that no arrangements had been made for us to receive presentations from midwives at the Shankill Road clinic. We were however able to question them informally about their view of the Domino Scheme. They suggested

> "We should be able to offer more choice to local women. We would be quite happy to do more home confinements and domino deliveries."

One midwife told us

> "I'd love to deliver my own women".

335. The midwives were invited to submit written evidence to the Committee. In this evidence they stated that

> "We are very keen to introduce a Domino system for delivery. Medical care could be given by the Consultant Obstetricians. All attempts to date have been met with a blunt refusal from the consultant".

On home confinement they said:

[468]Ev p 426 para 9
[469]HC (1990-91) 409-ii, p 50
[470]ibid, p 41
[471]Published by the Health and Social Services Management Executive, DHSS (NI), June 1990

> "[It is] extremely difficult for the mothers and the woman must be a strong individual to obtain a home confinement. Very few General Practitioners book women for home confinement although will respond to a medical emergency".[472]

This contrasts with the statement made in the memorandum submitted by the Northern Ireland Department of Health and Social Services that:

> "Women should, as far as practicable, be able to choose and have access to the type of care which they feel is best suited to their needs".

336. Our visit only took us to Belfast, so we were not able to assess the extent to which alternative approaches to care are available in the other parts of the Province. However our general impression was that consultant led care was the only form of care available. Even the midwifery teams to be introduced at the Royal Maternity Unit are to be led by consultants.

337. We were informed that there had been a recent restatement of the Baird Report (1980) by an Expert Working Group. It has recommended a concentration of services in obstetric units with over 2000 deliveries a year. We have since received the report which in fact recommends that "Each unit should have at least 2000-2500 deliveries per annum" with full obstetric, paediatric and anaesthetic cover. This plan will inevitably lead to the closure of smaller units unless there is an imperative demographic or geographic reason to retain a unit.

338. This centralisation of services does not accord with our recommendations about maternity services in England elsewhere in this report. Indeed, it runs entirely counter to the philosophy of providing women with the availability of a wide range of options. The pattern of provision in rural areas like the Bath health authority area and Brecon should be examined, and the lessons learnt applied to Northern Ireland. We deplore the decision of the Northern Ireland Department of Health and Social Services to promulgate these regressive proposals in the face of all the evidence about what consumers want. **We recommend that the proposals of the Northern Ireland Department of Health and Social Services contained in circular A585/91, issued in August 1991, be withdrawn and reconsidered.**

Midwives

339. We are persuaded that the key to the development of a pattern of maternity services which is more flexible and responsive to women's needs is a reassessment of the role of midwives. They represent a resource which is inefficiently and inappropriately deployed in the NHS at present, and we believe that there is the potential to unlock very considerable resources to fuel the development of the maternity services at perhaps relatively little cost. What we have seen and heard of the development of genuine team midwifery services persuades us that these represent the most promising way forward towards developing a pattern where women can approach, if not achieve, the ideal of one-to-one care and continuity between antenatal, intrapartum and postnatal care. Although we would expect a variety of working arrangements to emerge, we would stress the Committee's firm desire that the introduction of any new system (whether midwives having their own caseloads, midwife teams or a combination of both) must be underpinned by the criteria of continuity of carer, and the opportunity of the woman to meet and know her delivery attendant. **We recommend that the department vigorously pursue the establishment of best practice models of team midwifery care. We believe that as well as research this will require the allocation of pump priming money to fund the transitional costs of moving to a new pattern of service. There is no evidence to suggest that such a pattern of care must be more expensive overall than at present, and we are convinced that it will provide better value for money.**

340. While we welcome the Department's initiative in funding the 'Mapping Team Midwifery' research project,[473] we note that it is designed in the first instance only to establish what currently is being done in the name of team midwifery to promote continuity of care.[474] We believe there is an urgent necessity to build on this work to evaluate what patterns of working do actually increase continuity, and to assess what changes are needed in the ways in which midwives are employed and deployed to promote this.

341. The RCM wrote to us detailing some examples of where midwives were positively frustrated in their efforts to provide the kind of care individual women requested by unnecessary interference by managers in their working practices.[475] For example, midwives who wished to remain with a

[472]MS285
[473]Ev p 316, 2(c)
[474]Q1547
[475]MS419

woman to complete a delivery outside their normal hours have been told that the health authority cannot provide indemnity in such circumstances, and that they must hand over to another midwife at a critical stage of labour. Similar obstacles have been put in the way of midwives who wish to conduct home deliveries. **These practices do not appear by any means to be universal, but they must nonetheless end immediately.**

342. In the longer term, when midwives are given the duty to manage their own caseloads, their terms of employment must recognise their professional status and encourage them to make their own judgement about the best use of their time. We heard from the midwifery teams we met in the Rhondda how they successfully managed themselves to meet the demands of the women they served rather than rigid requirements about working hours which suited the convenience of personnel managers. There is an urgent need to move rapidly towards this pattern of working. We should no more expect midwives to sit around shuffling paper or twiddling their thumbs in order to fit in with rigid shift patterns than we expect such things to be imposed upon obstetricians. They should work as salaried professionals, not as hourly workers. Midwives' terms of employment must be designed to give priority to the needs of mothers.

343. We have received no urgent request for an increase in the number of midwives in this inquiry. We believe this is because midwives recognise that they are forced to use their time inefficiently in the present structure of the maternity services. A great deal more could be done with existing resources to meet the needs of women if midwives were treated as proper professionals. There are some 35,000 practising midwives in the UK and some 650,000 births per year. Even allowing for part-timers, managers and non-working midwives within that total, there must be approximately one working midwife for every 30 births each year. That, with that level of provision, we are still failing to provide women with what they want is a striking demonstration of how inefficient is the present use of midwives by the NHS.

344. The successful development of team midwifery will demand great energy and commitment from midwives themselves. We have been disturbed by the evidence we have received of demoralisation and deskilling amongst this expensively trained profession. The RCM tell us that out of 104,423 qualified midwives in the UK, only 34,629 registered an intention to practice last year.[476] The medical professions have also expressed some doubt as to whether their training currently equips them to take on this enhanced role. To generate that commitment amongst midwives will require the rekindling of pride in their role and the restoration of its status as an independent profession. **To this end we recommend:**

- **that the status of midwives as professionals is acknowledged in their terms and conditions of employment which should be based on the presumption that they have a right to develop and audit their own professional standards;**
- **that we should move as rapidly as possible towards a situation in which midwives have their own caseload, and take full responsibility for the women who are under their care;**
- **that midwives should be given the opportunity to establish and run midwife managed maternity units within and outside hospitals;**
- **that the right of midwives to admit women to NHS hospitals should be made explicit.**

345. In the context of the development of the profession of midwifery, we were disturbed by the anxieties we heard expressed by some witnesses[477] about the Nurses, Midwives and Health Visitors Bill which has been passing through Parliament while we have been conducting this inquiry. We have not taken sufficient evidence to reach any firm conclusions on this matter, and we acknowledge the consensus that has been achieved both within Parliament and the professional groups involved about the terms of the Bill. However, we also acknowledge the view expressed to us by Miss Bourne[478] that a profession without its own governing body and its own powers of standard setting and discipline is not a true profession as we understand it. We hope that when the recommendations of this report have been implemented and tested, perhaps by the end of this century, we will have reached a position where midwives will be fully acknowledged as an independent profession deserving the status that goes with such a position, and that this will be acknowledged by statute.

[476] MS446
[477] eg MS420 and also Midwives Registration Group
[478] ibid

General practitioners

346. The current role of GPs in the provision of maternity care in the community has been one of the more vexed questions which we have had to address in the course of this inquiry. This Committee acknowledges, without reservation, the pivotal role of the GP in the provision of primary health care for mothers, babies and their families in all aspects. We also acknowledge that pregnancy, birth and infancy are times when the GP should be expected to be particularly concerned about the overall health of the families for which they have responsibility. However, we are concerned that in the evidence presented to us the function of the GP in the 'team' which looks after a woman during pregnancy and childbirth has too often been seen as superfluous if not positively obstructive. The loss of skill and loss of confidence among GPs in the provision of intrapartum care has largely (and regrettably, we believe) made it impossible to provide the continuity of care which women are asking for with *specific* reference to pregnancy and childbirth (which for healthy, young women, as Dr Waine of the RCGP acknowledged,[479] may be the firs time they come into regular contact with their GP). We also heard a good deal of evidence that the system of shared antenatal care was producing either unnecessary duplication of the work of midwives or undesirable marginalisation of the role of community midwives.

347. If we are to see the establishment of a midwifery-led maternity service for normal pregnancies, as we have recommended, then we believe it will be necessary to reassess the role of GPs in the current system. **We believe that it is the system of item-of-service payments for maternity care, as presently operated, which drives the pattern of service delivery in an inappropriate fashion and we recommend that it is abandoned and redesigned, starting with a focus on care targets rather than the remuneration of GPs.**

348. In reconsidering the role of GPs in maternity care, we believe that any new pattern of involvement must be flexible and adaptable to local circumstances. Certainly, in rural areas where GP units exist and women are far from hospital, their role is likely to be different from urban areas. We have heard much praise from women for the support that GPs have given them through pregnancy and childbirth, and we believe, in the spirit of freedom of choice that we wish to permeate maternity care, that the option of a GP to care for women in pregnancy and childbirth should be maintained. If any system of item-of-service payments were to be retained in any new pattern of remuneration of GPs **we recommend that it should be very heavily weighted towards rewarding those who provide intrapartum care and therefore that continuity of care which is so crucial.** It may also be appropriate that other aspects of maternity care such as an initial medical check-up for a woman's overall health at the start of pregnancy, unless she has had a preconception check-up which is even more desirable, and a final postnatal check up of mother and baby at about six weeks after pregnancy, would be met by such payments. A mid-term check, in consultation with the midwives, might also be desirable. However, no system should replicate the current confusion of the midwife's and GP's roles in maternity care. We believe that some system of capitation payments for women of childbearing age could be the best way of rewarding GPs for *appropriate* care in the general health of mothers and their babies. **We recommend that all these options be urgently considered with a view to revising the GP contract.**

349. We were disturbed by the amount of evidence we received that GPs were obstructing women who wished to choose a different pattern of maternity care from that of shared care with a hospital confinement.[480] It is difficult to judge how widespread this is from the evidence we have received, but it is certainly clear that it is not happening only in a tiny minority of cases. **We recommend that the Department of Health take steps to impress upon all GPs their duty to facilitate the wishes of women, especially in respect of their choice of place of birth and their right to midwifery-only care. FHSAs should also take steps to impress upon all GP practices that it is wrong to remove a woman from their list solely because they wish to have a home confinement, or midwifery-only care, and we recommend that they introduce appropriate safeguards to prevent this.** It has been suggested that it should be a duty placed upon all GP practices above a minimum size to have one partner willing and able to provide intrapartum care. We do not believe that this is likely to be feasible, but **we recommend that it be a duty placed upon all GP practices to have in place arrangements for women to have a home confinement with GP cover or midwife-only cover if they so desire.** This recommendation has implications for the training of GPs in obstetrics which we consider in the next chapter.

350. We examined the Minister in oral evidence as to whether there was any substance in the reports that GP fundholders were to be given the power to purchase maternity care. After some

[479] QQ673-675
[480] see Chapter II

hesitation, she stated unequivocally that no such decision had yet been taken.[481] We welcome this. We do not consider that the extension of such a power to GP fundholders would, at this time, facilitate the reorientation of maternity care that we have identified, and which the Minister agrees is[482] necessary. Indeed, we are concerned that any such development would further fragment the pattern of delivery of maternity care, and frustrate attempts to make it more appropriate to women's needs. **We therefore recommend that no decision be taken on the extension of the power to purchase maternity services to GP Fundholders until the Government's response to this report has been published and sufficient time has elapsed to allow full consultation on it to take place.**

Obstetricians

351. The role of obstetricians in the pattern of maternity care that we have been debating in this inquiry has been controversial. Some witnesses have argued that much of the blame for the ills that they identify in the way maternity care is now delivered can be laid at the door of the RCOG.[483] This viewpoint was expressed by Mrs Marjorie Tew, once again displaying her 'revolutionary' side, when she said:

> "... things go wrong often, not from natural causes, but because of obstetric treatments intended to be preventive but in fact provocative ... it is now unquestionable that obstetric interventions at any stage, using high technology, much more often do harm than good".[484]

Such assessments of the history of maternity care remain speculative, unsupported by objective evidence.

352. The RCM took a more moderate position, but nonetheless maintained that the resources applied to 'high risk' pregnancies (and thus by implication to obstetric models of care) had been too high in the past.[485] They also believed that midwife-led care would reduce the number of interventions[486] and were cautious about endorsing any claim for an increase in the number of obstetricians.[487] Similarly qualified views were expressed by some of the consumer groups who gave evidence[488] and others who asserted or implied a causal relationship between the growing prevalence of obstetric care and the incidence of interventions. Equally, we have heard of much excellent and sensitive care provided by individual obstetricians.

353. In contrast, many comments have been made by medical professionals to the Committee suggesting widespread concern with the medical staffing of labour wards, mainly in terms of seniority but also in terms of absolute numbers. This was particularly highlighted by Mr John Friend, senior consultant obstetrician at Plymouth General Hospital. He wrote that:

> "The single factor that could make the largest contribution to lowering perinatal morbidity and mortality and increasing the quality of care for each mother and baby in the District General Hospital is a dramatic increase in appropriately trained "manpower"".[489]

354. Mr Friend reported that in 1990 the average number of deliveries per consultant in Scotland was 416, which is in line with the Royal College of Obstetricians and Gynaecologists' guidelines of one consultant per 500 deliveries. The figure for England and Wales is one consultant per 788 deliveries and for the South West Region one consultant per 820 deliveries. In Plymouth there is now one consultant per 967 deliveries, six consultants in all. In Newcastle, New South Wales, Australia, a city the same size as Plymouth, there are 38 specialists in Obstetrics and Gynaecology. However, it is worth drawing attention to some comparative statistics as between Plymouth UK, Newcastle, Australia and Scotland, which show the best outcomes in Plymouth UK, to show how caution should be exercised in drawing conclusions from such figures.

[481] Q1537
[482] Q1524
[483] See Chapters I and II
[484] MS216
[485] Q977
[486] Q952
[487] Q401
[488] see Chapter II
[489] MS152

ALL FIGURES ARE FOR 1990

	Total Deliveries	Consul/ Obstets	Ratio Consult/ deliveries	Caesar Section	Induction rate	Perinatal mortality per 1000
Plymouth UK	5260	5	1:1052	10.1 per cent	15.1 per cent	6.8
Newcastle NSW	6192	38	1:163	15.4 per cent	26 per cent	10
Scotland	65556	120.4	1:544	14.8 per cent	21.4 per cent	8.7

355. Mr Friend went on to point out that with the increase in specialisation and developments in gynaecology (such as endometrial ablation), the increasing involvement of senior doctors in management, and the demands of audit, many consultants have less and less time for the 24 hour a day seven day a week demands of the labour ward. Since the specialty of Obstetrics and Gynaecology is already in balance in relation to senior registrar and consultant posts, any increase therefore needs to be in both grades.

356. The Committee as part of their enquiry visited Hinchingbrooke Hospital in Cambridgeshire, where they were impressed with the medical staffing structure, in which senior house officers are responsible directly to consultants, without the usual intermediate registrar tier. One of the Hinchingbrooke consultants, Mr John Hare, wrote to the Committee:

> "The Committee should be aware that, in the United Kingdom, the majority of obstetric litigation cases relate to the unsupervised decisions and actions of junior doctors".[490]

357. The same point was made by the Association of Supervisors of Midwives when they wrote that:

> "Obstetricians should give junior medical staff more support when dealing with abnormal deliveries and thus reduce the prospect of litigation when mishaps occur through inexperienced decision making".[491]

358. Maeve Ennis, a psychologist working at University College Hospital in London, has carried out a study of the attitudes of junior obstetricians in training. Her findings indicate that:

> "Many Senior House Officers on obstetric units, both at teaching and district general hospitals, believe their training to be inadequate for the work they are expected to carry out in labour wards and delivery suites. Many also report little or no supervision, although most are carrying out sometimes quite difficult and complicated deliveries".[492]

> "Most obstetric senior house officers in this study, even in academic departments, reported receiving only one or two hours teaching or lectures a week and in some smaller district general hospitals received even less. Recognition at all levels that the senior house officer grade is a training grade is called for, with more comprehensive training that concentrates on those aspects of practice in which problems commonly arise. This would be of particular long term help to senior house officers continuing in the specialty (whether in hospital or in general practice) and would improve patient care".[493]

359. Ms Ennis also studied 64 cases on the files of the Medical Protection Society, and found that inadequacy of supervision and training was a factor in most of these accidents.[494]

360. Ms Soo Downe, a midwife researcher, wrote to us that:

> "At present, in many situations, there is much role confusion, as Senior House Officers assume the responsibility for cases although often feeling inadequately prepared. Such role confusion can be catastrophic for the care of women".[495]

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[490]ibid
[491]MS146
[492]MS205
[493]Ennis, M. (1991) Training and supervision of obstetric senior house officers. British Medical Journal 303 1442-1443
[494]MS205
[495]MS208

361. The Department of Health have reminded us of the objective stated in the MSAC's second report, namely that:

> "In every consultant unit there should be a doctor immediately available for the delivery suite, who should have no other conflicting commitments. A consultant obstetrician or his deputy should be available to take over from junior medical staff when necessary. It is of benefit if the consultant on duty visits the labour ward several times each day to ensure that problems are spotted early and subsequent care is properly planned".[496]

362. Achievement of such standards is clearly difficult when 29 hospitals in the UK still have only two consultants (who are also responsible for emergency gynaecology), and the vast majority of the remainder have only 3 or 4.[497]

363. **We recommend that maternity units should be required by purchasing authorities to make explicit their arrangements for senior medical staff availability for intrapartum care in abnormal labours.**

364. **We recommend that senior house officers should function as trainees, with principal responsibility for normal labours being taken by midwives. Abnormalities in labour should be dealt with by registrars who should always have the option of direct supervision by trained obstetricians (at senior registrar or consultant level).**

365. To achieve these standards, this Committee realises that some increase in the number of consultant obstetricians may be needed. We have looked at the suggestion that England should achieve parity with Scotland, and the RCOG's suggested target of 1 consultant obstetrician per 500 births. We have looked at costs. When the Government announced on 27 February 1990 that an extra 100 consultant posts were to be established, it estimated the cost to be £37 million per year. The House of Commons Library estimates that the cost per consultant post established (updated to February 1992) would be about £450,000. We have no reason to think that obstetric consultant posts would be very different from the average. To achieve the RCOG target would require nearly 300 extra consultant obstetricians. If this very costly exercise could be shown to be necessary, then we would favour it.

366. However, we bear in mind that we have made recommendations which should result in more work and responsibility being taken by midwives, which should free obstetricians to devote more time to their essential job. On the other hand, we are also keen to see the reduction of junior doctors hours and we realise that this, along with our recommendations on training, will mean more work for the consultants. We find it impossible to balance the effect of these opposite trends in order to suggest a target for increase. **We recommend that all these factors be evaluated in practice and that the number of consultant posts be increased where and when a specific need is established. We also recommend that the criterion for evaluating practices and costs should always be: will it result in a "health gain".**

367. The principle of continuity of care, and the ideal of one-to-one management of a woman's pregnancy and birth apply with equal validity to the circumstances of 'high risk' women as to normal pregnancies. Our proposals for the development of a community based midwifery model of maternity care should result in a more rational division of labour, in which obstetricians are enabled to give close attention to women who need it, and have time to provide the support and counselling that families which confront abnormalities and bereavement in pregnancy and childbirth need. Additionally, we believe that the more flexible and responsive system of maternity care that we wish to see developed will require a level of consultant cover which is compatible with providing the medical back up for a wider choice of places of birth and the establishment of truly community-based maternity care. We have heard evidence that consultants or senior registrars, with their other commitments, are not always available to attend emergencies or train juniors on the labour ward. **We therefore recommend that, in determining the appropriate level of medical cover for any maternity service, a priority must be the need to allow for the adequate availability of senior medical staff for duties, emergency or otherwise, on the labour ward.**

368. We have received evidence that suggests that there is an inherent bias in the education and culture of the obstetric specialty which pushes it in the direction of a pathological view of pregnant

[496]Ev p 183, para 5.3

[497]Manpower in Obstetrics and Gynaecology, RCOG 22.3.91

women.[498] We reserve our more detailed recommendations about training until the next chapter. However, there does seem to us some merit in the arguments we have heard that the institutionalised yoking together of the specialties of obstetrics and gynaecology encourages this culture. We believe that it should be open to some doctors to choose to become full-time obstetricians with their overriding commitment being to maternity care. **We recommend that the Royal College of Obstetricians and Gynaecologists, in consultation with the NHS management, explore the possibility of developing, where appropriate, obstetrics only consultant posts and academic posts within teaching hospitals. It may also be appropriate for some posts to be gynaecology only.**

369. We have referred to the evidence from consumer groups which suggests that the small number of women in the specialty of obstetrics has a malign influence on the course of its development, as well as possibly risking depriving of proper medical attention those women who, for cultural or religious reasons, will only accept such care from a woman. Whatever the merits of those particular arguments, we are convinced, like the Minister of Health[499] that an increase in the proportion of women obstetricians could only be highly desirable. Miss Mellows, herself an obstetrician, told us in oral evidence:

> "I do think the staffing problem is very important, and it is not just job satisfaction, it is the quality of life. I am concerned about the number of women who go into our specialty and then leave it and part of the problem is the hours of work. You become a consultant and then you are on call one in two or one in three, and this is very large commitment and it is something which people ... should not be expected to do. They cannot run their lives satisfactorily, particularly the women with families".[500]

370. At present approximately half of all doctors qualifying are women, but as "Women in Gynaecology and Obstetrics" wrote to us, only 12 per cent of consultants are women.[501] Luisa Dillner, writing in the British Medical Journal, points out that this percentage has not increased over the last 25 years.[502]

371. Dr Bernadette Fuge, Senior Medical Officer, Health Professional Group, Welsh Office, told us that:

> "We also have a great problem as you know, in staffing hospital obstetric units where they are having a difficulty with recruitment".[503]

372. The second survey of manpower by the Royal College of Obstetricians and Gynaecologists, published in March, 1991, stated that:

> "There is evidence that obstetrics and gynaecology is in serious danger of becoming a shortage specialty both objectively from the reduction in the number of career SHOs (249 in 1986, 191 in 1989 and 148 in 1990) and subjectively from junior staff interviews".[504]

Mrs Susan Blunt, a consultant Obstetrician and Gynaecologist at Solihull Hospital in the West Midlands, wrote in an editorial in the British Medical Journal on 7 December 1991 that:

> "Obstetrics and gynaecology is a fascinating, innovative and progressive branch of medicine encompassing two acute specialties and combining medicine and surgery with the excitement of midwifery. Yet there is clearly something wrong because recruitment to and retention in the specialty have deteriorated. Over the past five years the number of United Kingdom graduates obtaining membership of the College has not increased to match the small increase in consultant numbers; the number of United Kingdom senior house officers has fallen steadily to critically low levels; and there is an alarming wastage of trainees after membership, with a third leaving the discipline within five years of membership (53 per cent of women, 27 per cent of men)".

373. **We recommend that the Department of Health take positive steps to accelerate the rate of implementation of reduced hours of work for junior medical staff in obstetrics, to no more than 72 hours per week. Moreover, the Department should encourage the investigation of new working practices, such as shift work, part time working, and job shares, which will make pursuing a career in**

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[498] see Chapter III
[499] Q1552
[500] Q512
[501] MS224
[502] Maternity Services: the shaping of things to come. British Medical Journal 302 1198-1200
[503] Q1469
[504] Manpower in Obstetrics and Gynaecology, Royal College of Obstetricians and Gynaecologists, 22.3.91

obstetrics and gynaecology more compatible with a normal family life. Since the short term nature of most junior posts militates against proper arrangements for maternity leave, which are quite properly regarded as essential in other walks of life, **we also recommend that consideration is given to arranging two year rotations within a local geographical area, to enhance job security. Further, we recommend that formal arrangements for funding maternity and study leave be reviewed and brought up to the best EC practice.**

Special and intensive care units

374. Concerns have also been expressed to the Committee about the level and pattern of staffing in neonatal special care and intensive care units. The Royal College of Physicians has provided recommendations for the medical staff required in regional and subregional perinatal centres, and in special care units that do not undertake long term intensive care.[505] The BPA and BAPM have endorsed these recommendations.[506] The BPA[507] told us that the number of consultants specialising in neonatal care in England and Wales was 63 in 1991 and that in order to meet the recommendations 125 were needed. The RCP calculated that slightly more, 151, were needed to provide a satisfactory regionally based service. For general paediatricians providing neonatal as well as other paediatric care at district level the BPA stated that the numbers would have to increase from 570 to 1150-1500. These increases may seem large, but it was put to us that paediatricians, both consultants and junior staff, work excessively long hours compared with most other specialties. Professor Hull reminded us that "... the Minister has made the statement that doctors will not work for more than 72 hours [on call each week] and wishes the task force to implement that by 1994. It has also been agreed with the Joint Consultants Committee in the Department that consultants would not be resident in hospitals to provide emergency cover ..". He went on "The evidence .. is that SHOs in neonatal medicine and in paediatrics work very long hours ... they work far longer than any other SHOs, and ... when they are on night call ... they are usually working all the time and at most they get four hours' sleep as a maximum". He concluded that

> "... quite a large number of neonatal services round the country will have to close down at certain times because there will not be the staff available to cover them. This is a simple straightforward consequence of the Minister agreeing with the profession that doctors will not work long hours and consultants will not be first on call in residence in hospitals. There has got to be some solution to that".[508]

375. Professor Hull told us that his solution "rests .. on having more doctors. You cannot do it by putting them on rota arrangements because they are already working excessively long hours."[509] When we asked for an overall figures of the shortage both at consultant and junior level he replied "... it just depends what sort of agreement the Minister wants to make to SHOs, but it is nearly like doubling the numbers".[510]

376. Mrs Jean Robinson of the Association for Improvements in the Maternity Services told us:

> "One of my concerns .. is that there is a very high burn out rate for doctors and nurses who work in this kind of [neonatal intensive care] unit. It is extremely stressful. One of my long term interests has been occupational risks for those in caring professions. When we are costing those units and designing them we have to think of the problems of staff who are working with tiny babies, are in daily contact with very stressed families, and in areas where they know there is going to be a high mortality and morbidity rate. You really should not underestimate the difficulty of doing that job and how much support people need. They [doctors and nurses] may also need extra study leave and other things, but we have to look at the needs of caring staff ..."[511]

377. We conclude that it is quite unreasonable that staff should be forced to work such unacceptably long hours in such a demanding environment. **We therefore recommend that the medical staffing levels recommended by the Royal College of Physicians, the British Paediatric Association, and the British Association of Perinatal Medicine for the provision of care for newborn infants in regional and subregional perinatal centres, for the care of babies in special care units and for the supervision of normal babies be adopted as a target to be achieved as soon as possible, and in any**

[505]Appx 11, Medical Care of the Newborn in England and Wales (1988)
[506]Paediatric Medical Staffing for the 1990s, pp 22-23, (1991)
[507]Ev p 418
[508]Q1075
[509]Q1076
[510]Q1081
[511]Q1218

case not later than 1995. We acknowledge that there are considerable resource implications of this recommendation.

378. With regard to nursing staff we asked Ms Paula Hale of the Neonatal Nurses Association what could be done to alleviate the pressures of working in a neonatal intensive care unit and to reduce the high turnover of staff. She agreed that retention of staff was difficult and continued:

> ".. the single most common factor for not being able to admit a baby into care is the lack of availability of the qualified-in-specialty nurse, the nurse with competencies and expertise to care for that baby. Many of the stressful situations result from the fact that the question of establishment has never been addressed. We are chronically under-resourced for neonatal nurses who are qualified in the care of the newborn".[512]

She went on to describe how lack of staff and the problem of having to refuse admission to ill babies had serious implications for the job-satisfaction and education of neonatal nurses, saying

> "There is very little in the way of support teams for neonatal nurses. Neonatal nurses in fact fill in all the gaps and deficiencies in the provision of the service and in this we are referring to housekeeping teams, clerical support, receptionist support. Large amounts of dedicated nursing time will be spent in routine non-nursing duties. In addition, specialist support roles, for example in the areas of family care and education are required".[513]

379. The Neonatal Nurses Association has together with the BAPM, formulated definitions of the trained nurse-staffing levels needed in neonatal units. The numbers required to provide 24 hour, seven days a week cover are: 5.5 nurses for each intensive care cot, 3.5 nurses for each high-dependency cot, and 1.0 nurse for each special care cot. These levels appear to us to be realistic in that, for example, when allowance has been made for necessary time off, no nurse will have to look after more than two babies undergoing intensive care at the same time. We think that proper support for neonatal nurses is a key issue in improving the services for the care of ill babies. **We therefore recommend that:**

- **The appropriate staffing levels as defined by the NNA be adopted as the norm and included in guidelines for accreditation of regional units.**
- **Proper support by ancillary staff should be provided in neonatal units.**
- **Adequate recognition of the stressful nature of the work - with proper time off, and study leave, should be ensured.**

We have made our recommendations about transitional care and community support earlier.

Postnatal care

380. The birth of a baby is the birth of a new family. This sensitive time of adjustment and change is severely neglected in our culture; the postnatal period is a huge transition for the parents of the new baby and needs to be seen as a time of adjustment to life as a family, but also as a time of reflection of what happened during the labour and birth and a time for the establishment of breastfeeding.

381. Professional help can enable a woman to allow herself enough rest and time for adjustment and can give her confidence in the handling of her new baby. Support groups run by the National Childbirth Trust can act as a model for breastfeeding groups and postnatal support groups, run by both health visitors and midwives. Their basic ingredient is to introduce mothers who live locally to each other, and to allow them a time and a place to gather together.

382. During our visit to Holland we were impressed by their system of Maternity Care Assistants which has no equivalent here. It involves three year training at Further Education level (normally 16-19 year olds) to equip the Assistant to help the midwife at the birth (35 per cent of births taking place at home), and then to follow up 8 hours a day for 8 to 10 days. In the case of hospital births, she starts after the mother's discharge from hospital. The Assistant is trained to care for the house and other family of the new mother. We think this scheme would repay investigation.

383. The scant evidence we have received about postnatal care confirms that it is a neglected area of our maternity services. We were impressed by our evidence we received from the Grampian Region about the inadequacies of present arrangements. **We recommend that this research be broadened and conducted in selected areas of England.** Managers of the midwifery services must concentrate more resources in this area by seeking a more appropriate deployment of antenatal

[512] Q1088
[513] Q1089

services. **We recommend that, in redesigning postnatal services, the need for continuity of care be placed at the centre.** For this reason, midwives will be the most appropriate providers of such care, and also the most appropriate resource to draw upon in setting up research projects. **We recommend that, in this area above all others, attention must be turned away from a medical model of care to a woman-centred approach which takes full account of their social needs.**

Conclusions

384. We summarise the broad principles of our recommendations relating to maternity care as follows:

- **That the relationship between the woman and her care-givers is recognised as being of fundamental importance.**
- **That schemes should be set up enabling women to get to know one or two health professionals during pregnancy who will be with them during labour and delivery, whether at home or in hospital, and who will continue the care of the mother and baby after birth.**
- **That the majority of maternity care should be community based and near to the woman's home; and that obstetric and other specialist care should be readily available by referral from midwives or GPs.**
- **That those GPs who wish to provide a continuum of care throughout pregnancy, labour and the puerperium should be able to do so; and that their training should equip them to do so.**
- **That women needing intensive obstetric care within the NHS should also be able to enjoy continuity of care and carer, so far as is possible.**
- **That within a hospital women should be able to exercise choice as to the personnel who will be responsible for their care.**
- **That the woman having a baby should be seen as the focus of care; and that the professionals providing that care should identify their needs and develop arrangements to meet them which are based on full and equal co-operation between all those charged with her care.**
- **That proper attention should be paid to the needs of the baby, with particular regard to skilled resuscitation at birth, examination for abnormalities, and the encouragement of breastfeeding.**

385. As we have stated earlier, this inquiry has not been intended as a further follow-up to the original report of the Social Services Committee in 1980 on Perinatal and Neonatal Mortality. Indeed, the evidence we have heard has led us, at certain points, to distance ourselves from some of its recommendations and to derogate at points from the overall philosophy of maternity care which it expounded. **However, we remain firmly convinced that the pattern of provision of special care and intensive care for babies that grew in part from the recommendations of the report of the Social Services Committee in 1980 remains the most appropriate and effective system of provision.** In the light of the wealth of evidence that we have received from the professional bodies that the regional services may be threatened, we believe that urgent steps should be taken to ensure their preservation.

CHAPTER VI: THE WAY FORWARD

Introduction

386. We have described in the previous chapter the shift in emphasis which we wish to see occur in the underlying philosophy, organisation and delivery of the maternity services in England. However, this report does not set out to be a 'blueprint' for the maternity services. The history of their organisation suggests that too often in the past the pattern of maternity care has been inflexibly delivered in accordance with rigid and excessively prescriptive preoccupations of those charged with its control. We do not wish this report to mark another extreme in the swing of the pendulum. We therefore turn in this final chapter to consider how a flexible and responsive pattern of maternity care can be developed and maintained so as to ensure that the maternity services become appropriate to women's needs, responsive to their wishes, accessible to all and efficient and effective in their organisation.

A National Framework

387. We take as our starting point the belief that to effect such a change in emphasis, the commitment of politicians, the Department of Health and the NHS Management Executive will be required to stimulate from the centre the new thinking that will lead to changes at the local level. The RCM said to us:

> "what we are talking about is midwives [being] in a position where they can make policies for the maternity services in collaboration with their medical colleagues ... they have to come locally, but there has to be a drive at national level ... to make this kind of reorganisation and change legitimate[514]... It would be much easier for midwives working out local protocols and getting agreements if there is a shift of emphasis from the centre and nationally".[515]

388. The RCGP admitted, more cautiously, that they would not preclude 'the setting of some overall national standard', while the RCOG laid great emphasis on teamwork and the importance of the work of the joint group of the three Royal Colleges in setting a national consensus on how they should work together to deliver maternity care.

389. The Presidents of the three Colleges agreed to make available to the Committee a confidential final draft of their report. While we cannot therefore discuss its contents in detail, we believe that it too marks a significant shift in emphasis. The evidence we have considered in the course of this inquiry has convinced us that we have already turned a corner in the way in which maternity care is thought about within the NHS. Interventions such as caesarian sections, induction and episiotomies show signs of having reached a plateau or in some cases to have begun to decline. Obstetricians, midwives and general practitioners are more ready to acknowledge that they have failed in the past to provide the kind of care that women want, and that they have pushed forward with developments without paying sufficient heed to what women are saying. They have also recognised and admitted that in many areas the maternity services are poorly organised and inefficiently deployed and that this has led to the misuse of human and financial resources. They have acknowledged unnecessary duplication of effort combined with serious gaps in provision of care. All this we find most heartening. In turn, we readily acknowledge that the failures at an institutional level are not replicated everywhere at a local level. Many women experiencing pregnancies and births receive sensitive and effective care from doctors and midwives, and in many areas the people involved in delivering this care work together happily as equal partners with the women using their services.

390. While we recognise the many successes of the maternity services at a local level, we believe much remains to be done to reorient the maternity services at a national level. The document produced by the three Royal Colleges strikes us, in this respect, as a somewhat bland (though welcome) statement of general principles rather than an agenda for action. We have identified the way in which midwives are used in the maternity services at present as an expensive misapplication of resources—a 'scandalous waste of money' in the words of one witness from the RCM. Yet the maternity services are still too often failing to deliver what women actually want from them. As we noted in the first chapter, almost every major report since 1948 has emphasised the need to use the resource represented by midwives more effectively. This call was reiterated as recently as September 1990 by the Committee of Public Accounts which, referring to differences of view over the role of midwives, suggested that the NHS Management Executive 'should therefore examine this question and, in particular, the possibility of giving midwives greater responsibility for the care of low risk pregnancies'.[516] The Treasury Minute in response promised more research.[517] But in the course of this inquiry we have had only promises from the Department of more research, and more vague undertakings to think about doing something about the problem. Instead of an acknowledgement of progress, we have heard from midwives that they continue to be inappropriately and inefficiently utilised to the detriment, we believe, of the entire maternity services.

391. The time has come to turn these vague promises of a reappraisal of the maternity services into a programme for action. The professional groups need to be galvanised into setting their own Colleges in order. We have also identified many aspects of the maternity services under the management of trusts and DHAs that require urgent attention and reform. We concur with the RCM that this will happen only if there is a determination at the centre to focus attention on these issues and to prompt a management response at local level.

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[514]QQ988-9

[515]Q995

[516]Thirty-fifth Report from the Committee of Public Accounts, Session 1989-90, HC 380, p. ix

[517]Cm 1323, p.12

392. We were fortunate to be presented during the course of our inquiry with an example of an initiative which we believe shows how such change can be effectively managed, rather than postponed. Not for the first time, we discovered that they order these things much better in Wales. In August 1991, the Welsh Office's NHS Directorate (the equivalent of the Management Executive in England) published its *Protocol for Investment in Health Gain: Maternal and Early Child Health.* This is the third protocol published by the Directorate arising from the work of the Welsh Health Planning Forum on local strategies for health: a new approach to strategic planning. We were sufficiently impressed by this publication to seize the opportunity of taking formal evidence from some of those involved in its preparation during our visit to Wales on 17/18 December 1991. Mr Wyn Owen, explaining the origins of the exercise which led to the protocol told us:

> "When general management was introduced in Wales, one of the things that I asked the Secretary of State to provide was a statement of policy and priority for the Health Service. In other words, 'if you want the service better managed, what is it that you actually want to achieve' ".[518]

and Mr Pritchard, pursuing the same theme, said:

> "We are trying to turn the equation round and say what are the health challenges, look at where we are now in terms of the health status and then try to work backwards to see what health services you need to improve health. The old-style approach to planning had been to ask the question, 'What maternity services have we got now and how can we make those better?' In our judgement that missed the point".[519]

and Dr Warner expanded on this by saying:

> "... we have to begin with the needs of people but then crucially we do not accept that the interventions that we have always done are necessarily the best ones".[520]

393. When pressed to say where the initiative had come from for this work to be done, Dr Warner told us that it had been a 'management drive' to get it started, but once started, it had engendered enthusiasm amongst the professionals to become engaged in the process. The benefits of this approach were described to us by Mrs Drayton:

> "Not surprisingly each group approached the task in what might be called their professional way; and so obstetricians and perhaps consultant paediatricians felt more technology and perhaps more resources would greatly enhance their ability to care for specific groups. Midwives were anxious their skills should be fully utilised. GPs felt the need to remind us they are the lynch pin of the NHS. The way in which we overcame these difficulties was to focus on health gain ... so whereas traditionally one might have said, 'If we had more of this or more of that service or input', every suggestion was tested against 'Will it achieve health gain?'"

394. We believe that this approach is the one that must now be adopted by the NHS management in England, for its benefits are clear for all to see in the document produced by the Welsh Health Planning Forum. We believe that this inquiry has provided ample groundwork to enable such an exercise to be up and running very rapidly; and we have identified in the previous chapters the key areas of health gain which such an exercise should focus on. The Royal Colleges have shown themselves to be collectively incapable of performing this function by themselves, and this comes as no surprise in view of the institutional perspective in which they are working. **We recommend that the NHS Management Executive be directed to establish a forum, modelled upon the Welsh Health Planning Forum, charged with the specific duty of preparing a national protocol which identifies the targets of the maternity services in terms of health care, and with the purpose of requiring health service purchasers to produce specific plans for meeting those targets. The key to achieving such targets will, we believe, be a radical reconsideration of the deployment of human and financial resources.** Local services must of course be responsive to local needs, but it is the duty of the centre to initiate the development of a coherent strategy for meeting those needs.

395. **We believe, in the light of this inquiry, that the publications of the Maternity Services Advisory Committee of almost ten years ago are superseded. We recommend that they be withdrawn and replaced by the publication of the forum whose establishment we have recommended above.**

396. It remains to be seen whether or not the initiative of the Welsh Health Planning Forum will produce change or run into the sands of apathy that has been the fate of too many similar initiatives. However, we believe that the spirit of reform is already permeating the maternity

[518] Q1453
[519] Q1454
[520] Q1454

services and that such a group could be the motor for change. In order to ensure that, over the next decade, that change is effective, there are a number of key areas which must be addressed. We identify these as: education; research, audit and evaluation; and the deployment of resources. We will consider each of these in turn.

Education

397. Concerns have been expressed to us by all the professional groups about the adequacy of their present systems of education to achieve the targets which need to be set in the delivery of maternity care.

398. We believe that the key to reforming the education of all the groups involved in maternity services will again lie in the clear identification of the care targets. That education must then make possible their achievement. Those targets should enable the appropriate contributions of each group to be more clearly identified, and overlap and interference to be reduced. At the same time, the key to successful delivery of the services required to meet those targets will be co-operation between midwives, general practitioners and obstetricians. They have much to learn from each other.

399. We have cited earlier in this report the evidence from the President of the RCGP and Dr Peter Kielty about how the current training of GPs focuses upon the abnormal and discourages them from regarding pregnancy and delivery as normal. It was also widely believed among witnesses that, if the training was modified and GPs could regain their confidence in this area, many more would wish to become involved. Certainly, on our visit to Wiltshire, where we found a culture that encouraged their participation, there was clear evidence of the beneficial effects on doctors' willingness to take a full part in maternity care. We also found a situation in which few of the tensions we encountered between GPs, obstetricians and midwives at a national level could be detected locally.

400. When asked about the willingness of general practitioners to be involved in continuity of care antenatally, during delivery and postnatally, Dr Waine of the RCGP said "I think you would find that if our education system was modified so that it did not frighten them out of intranatal care, a large number of people would wish to be involved in that way".[521] Dr Lindsay Smith, in a report on trainees' views on hospital obstetric training published in the BMJ,[522] stated that "hospital training discourages general practitioners from practising intrapartum obstetrics. Most trainees believe that their hospital training should be more orientated to general practice". Dr Gavin Young of the Association for Community Based Maternity Care believed that to increase the number of general practitioners wishing to provide intrapartum care in GP units

> "there would need to be a major alteration in the way we are trained. . . . I would like to see much more of that handed over to normality so that midwives were closely involved with the training and assessment of future general practitioners ... I think more of our training should be based in the community. For those who were going to do care at birth it would be necessary to have continued hospital experience".[523]

401. The RCOG fully recognised the need for a reappraisal of vocational training for general practice. We were told that a report on vocational training had just been produced by a joint working party of the RCOG and RCGP and that it had "also touched on midwives ... and ... highlighted one particular area in which we [the RCOG] would like them to be part of the educational team concerned with the general practitioner and the trainee doctors".[524] Professor Dunlop told us that the RCOG were in the process of reassessing their training for the Diploma Examination which is essentially designed for general practitioners. "A working party ... has been set up to try to look again at our educational objectives and to ensure that we train general practitioners in what they wish".[525]

402. The majority of routine medical care on labour wards is currently provided by Senior House Officers, of whom 58 per cent are those training for general practice and who spend six months in a department of obstetrics and gynaecology. The Royal College of Nursing Midwifery Society recommended that:

[521] Q665
[522] 7 December 1991, Vol 303, p 1447-1450
[523] Q1419
[524] Q943
[525] Q944

"Senior House Officers undertaking Obstetrics prior to General Practice should have a more formalised training into which there should be midwifery input".[526]

and that:

"Senior obstetric staff should be available at all times to teach and supervise junior obstetric staff. This is crucial in terms of maternal/fetal morbidity/mortality".[527]

403. We think it essential that the initial training of both career obstetricians and GPs should be based around the care of women with normal pregnancies and labour. That training should emphasise the need for understanding of the women's wants and needs.

404. The RCOG in its evidence recognised the necessity to involve GPs and midwives in the initial training of obstetricians. We are encouraged to learn that the Royal College of Obstetricians and Gynaecologists has recently reported on the training of career SHOs and Registrars prior to obtaining MRCOG and that a working party has been set up to look at the training for the Diploma of the Royal College of Obstetricians and Gynaecologists which most general practitioner trainees undertake. We are encouraged to note that the RCOG has now addressed the need to look at higher specialist training in obstetrics and gynaecology and the issue of mandatory continuing medical education for all specialists on a five yearly basis.

405. **We recommend that an urgent review of training needs for senior house officers be undertaken. We further recommend that the RCGP and the RCM be invited to participate in the review, and that any training programme devised contain at least a half-day of formal instruction per week. That instruction should be shared between obstetricians, midwives and general practitioners, and paediatricians should be involved in instruction about the newborn. Training at senior house officer level should concentrate on the normal, and those aspects of abnormality capable of being dealt with at general practitioner level.**

406. We are concerned about the current length of training of an obstetrician in this country prior to achieving a consultant status. When asked about the length of training in obstetrics in the UK as opposed to elsewhere, Professor Dunlop for the RCOG replied:

"I am not sure that it is quite as marked a difference as you have been led to believe. The average medical graduate graduates at the age of 24 years in this country, it would take four years for him to complete training for the MRCOG and after that he would require another three years to become fully accredited; so that it is a total of seven, which added to 24 makes 31. The average age of a consultant appointed in this country of course is higher than that, it is about 37 years and looking at that you have to take into account the fact that there are a number of appointments from consultants already in post and there are a number of other factors which influence age at appointment such as the appointment of consultants with an overseas background".[528]

407. We also heard from Jean Chapple in her evidence who wrote:

"When I meet junior doctors in obstetrics and gynaecology I am struck by how much they resemble that group of public health medicine trainees of fifteen years ago. They are demoralised, over-worked and are not encouraged to gain skills outside pure clinical work that would help them to tackle the daunting task of being a consultant in tomorrow's brave new NHS. Many have no idea of how to present a paper or use a computer. They have few management skills that would help them to work with other staff in an effective and efficient firm and they are not helped to deal with the stress of telling patients that they have an abnormal baby or an abnormal smear".[529]

and Dr Wendy Savage expressed the view that:

"Too often the end product of the piece-meal, arduous and exhausting years on-call 'See one, do one, teach one' style of training is insensitive to womens' needs and incapable of sharing the work with colleagues and midwifery and General Practice ... For women the long training period before appointment to consultant position is particularly difficult to reconcile with having children or deferring childbearing whilst delivering other women".

We recommend that the RCOG and the NHS Management Executive jointly review both the length and content of obstetric training. We further recommend that at the completion of training, when

[526]MS 226
[527]ibid
[528]Q452
[529]MS49A

doctors become accredited, their employment should reflect their status as fully-trained, independent practitioners.

408. The Association of Radical Midwives told us that Midwives in the UK either train for three years to become midwives or for 18 months following a three year nurse training. They described the competencies of the midwife and the training programme required by the European Community Midwives Directive.[530] The basic training is likely to be sufficient to prepare the midwife for the role and most of the responsibilities recommended in this report.

409. We have heard however from many sources that the current position of the midwife in the NHS results in the underutilisation of her potential skills, and that in most services she works in a disjointed manner rather than the holistic way we are suggesting for the future. AIMS stated in its evidence that "Expensively trained midwives are being used for trivial work in hospitals, the community and GP practices. Many of them no longer deliver babies".[531] This was confirmed by Ms Lesley Page (RCM) who told us:

> "What happens in the present system is that it is quite fragmented and midwives might work in one area of the service and not another, so we find midwives who have not delivered a baby for many, many years, for instance. We also find that midwives are being used sometimes as receptionists or chaperones and, in some situations, in antenatal clinics they can just be testing urine, weighing the woman and admitting her, rather than actually doing an abdominal examination to see how the baby has grown and talking to the mother and getting an assessment of the health of mother and baby".

410. We have reason to believe that this pattern of midwifery misuse is widespread, and we cannot therefore be complacent about the level of in-service training that will be needed by practising midwives in order to meet the recommendations of this report. **We would recommend therefore that all those who are involved in the provision of statutory periodic refresher courses and in-service up-dating for midwives base a substantial element of future courses upon the presumption that midwives will be working rapidly towards the recommendations of this report.**

411. We also believe that when progress is made towards integrated, rather than fragmented, midwifery, this will itself facilitate professional development. Ms Page of the RCM encouraged this view when she said:

> "One of the most important things about following a woman right through her pregnancy is that you see the outcomes, whether they are good or bad, and you know immediately if you have given good care or bad care, ... whereas in our present fragmented systems we do not always know what the end result is for the mother, the baby and the family. I think that any of us who have seen midwives reorganised into practices, which I think is a useful term to think of, see an improvement in the development of skills ... which is very dramatic indeed".

412. Doctors are concerned about the risks to the newborn baby of an increase in midwifery-only care outside consultant obstetric units. Dr Harold Gamsu wrote:

> "Sudden acute emergencies arising in a baby during or after delivery may need more expert help than the midwife can provide, and the same has been known to happen during the early neonatal period. General Practitioners are not always involved in the delivery nor in the subsequent care of the baby and they and their midwife colleagues may not be experienced or equipped to deal with these neonatal problems".[532]

The ability to provide adequate facilities for resuscitation is of particular importance. Dr Rivers believed that "... the midwife/doctor delivering the baby must be trained to recognise the importance and signs of ... any inability to establish the breathing and circulatory changes essential for normal survival"[533] and the National Birthday Trust emphasised how important it is that anyone who delivers can resuscitate a newborn baby and that "Basic skills should be taught, retaught, tested and retested."[534]

413. We asked Professor Hull of the BPA whether midwives could, with suitable training, take over full responsibility for resuscitation. He replied:

> "It was suggested that midwives twenty or thirty years ago should be trained [in] tracheal intubation resuscitation and that endeavour I was involved in came to nothing. If it is the view

[530] 80/155/EEC Article 4 (MS76)
[531] MS277
[532] MS316
[533] MS175
[534] MS189

that babies may adequately be resuscitated with the face mask, which is ... the way they have solved the problem in Sweden, then certainly midwives are well able to do that ... but in Sweden they have found that there are still occasional babies whose life depends on tracheal intubation and artificial lung ventilation. I think experience has shown that midwives on the whole do not do it frequently enough to acquire the necessary skills".[535]

For babies born at home or in small units, even if selected on the basis of low risk, it must be accepted that a small minority will fail to breathe. Dr Luisa Dillner, of the BMJ, wrote:

"What providers of care must ensure is that there is back up in the community in case things go wrong. This may mean that midwives must become skilled in resuscitating the newborn and that general practitioners should make themselves available to attend midwife deliveries".[536]

414. We conclude that it is vitally important that appropriate facilities are provided for the skilled resuscitation of babies who fail to breathe at birth, wherever they are born. In obstetric units skilled assistance from paediatric staff is, or should be, readily available. For births at home or in small units, the responsibility for resuscitation of the baby will usually rest with the midwife. **We therefore recommend that the training of midwives and GPs in the resuscitation of newborn babies should enable them, so far as possible, to keep babies who do not breathe alive and in good condition until such time as skilled assistance is available. This will require constant in-service training and retraining, and the resources necessary to provide this. Wherever possible, we recommend that a second pair of hands should be available, in case the mother and baby need attention at the same time.**

415. On the issue of the first examination of the newborn baby, Professor Hull believed that the amount of training required would be similar to that of a doctor.[537] The Committee is of the view that the proposed increased role of the midwife in maternity care requires a particular review of the training needs of midwives in neonatal examination and resuscitation and **we recommend therefore that the United Kingdom Central Council instigate such a review as a matter of urgency in collaboration with the British Paediatric Association.**

416. This report has recommended changes that should strengthen the midwifery profession. This we have done because of our belief that this will be the most effective way to achieve a service that will meet the range of needs of women. The future education of the midwife will therefore be crucial to this change. We have been disturbed by evidence received that midwifery education is in danger of being subsumed into nursing education. Mrs Elaine Emmons, a head of midwifery education, wrote to us saying

"As Head of Midwifery Education I found myself invited to do validation and other consultancy work at Colleges of Midwifery throughout this country. To my dismay I found that many of our pre-registration courses are turning out to be Project 2000 type courses in disguise. The midwifery profession voted unanimously to reject joining Project 2000. However our courses are being altered by non-midwives so that midwifery courses come into line with nursing courses. Locally in Dorset the Principal of the Dorset and Salisbury College of Midwifery and Nursing has altered a midwifery degree course substantially. The result is that 15 weeks of clinical placement have been taken out. This would cause the student midwives to lose out on clinical experience which is detrimental to their ability to practice midwifery as a "practitioner in their own right." As midwifery education is linked to nursing, midwifery educationalists are put under tremendous pressure to make these changes. It is important that your committee investigate into the situation before we find that future midwives have turned into maternity nurses, unable to give the kind of care that our clients require".[538]

417. Having spent a year on our inquiry into maternity services, and having reached the conclusion that to have midwives working independently but in close professional co-operation with their medical colleagues is the best route to excellence, we are firmly persuaded that it is essential that midwives should set, govern and audit their own standards of professional education. **We recommend that midwives should be afforded the same rights as all other professions over the control of their education. Whether in NHS or other institutions, midwifery studies should be afforded independent faculty status. Selection of candidates, curriculum planning, assessment processes and course validation must remain under the control of the midwifery profession. We would expect these principles to be upheld not only in the training establishments but also by the statutory bodies that set overall national standards for training and approve and monitor the courses.**

[535] Q1098
[536] MS227
[537] Q1101
[538] MS395

Research, Evaluation and Audit

Research

418. It has not been a central part of our remit in this inquiry to consider research. We have, however, identified a number of serious gaps in the current state of knowledge about maternity services which should be urgently addressed. We have also identified areas where good work appears to be being done which requires support and development.

419. We were astonished to learn how little is known by the Department of Health about the relative costs of different aspects of the maternity services,[539] and how compromised was some of the current received wisdom about costs of such things as team midwifery, domino deliveries and peripheral maternity units. Nor did we uncover convincing evidence that serious efforts had been made to evaluate the costs and benefits of many of the procedures that currently form part and parcel of maternity care. Antenatal care was widely acknowledged as inefficient, over-provided and inappropriate. Too many fashionable interventions in intrapartum care have been introduced without evaluation either of cost-benefit ratios or the reactions of women who undergo them. We feel confident in asserting that many millions of pounds are wasted annually in these areas, though it is impossible to put any firmer figure on the sum. The Committee of Public Accounts, in its 1990 report on the maternity services to which we have already alluded, noted that 'The Management Executive could not give us a clear assurance on the efficiency of maternity services costing £700 million a year'.[540] In its response, the Treasury referred to the hospital information systems programme.[541] We have discovered in the course of this inquiry the chaotic state of these systems. No significant progress has been made towards costing the maternity services in a way which would enable those responsible for delivering them to make informed decisions about whether they met their targets (which are themselves ill-defined and often inappropriate) in a cost-effective manner. We are convinced by this inquiry that much of what is done in the name of maternity services is a waste of money, while many important needs remain unacknowledged and unmet.

420. For example, postnatal care appears under-provided and almost entirely unexamined. Little or no effort appears to have been made to assess either the social or medical costs of neglecting women or leaving them often unsupported at this crucial time. It appears that women are not infrequently turned out of hospital in accordance with managerial preoccupations with bed-throughput with scant regard for the circumstances into which they are returning or for their medical, let alone social, needs. The levels of maternity benefits appear to have been fixed entirely with reference to budget constraints and with no attempt made to examine the scientific or medical basis for assumptions or the social costs of arbitrary decisions. Similarly, the Government appears to be beginning only now to be dimly aware that there are many costs to be weighed in the balance with that of proper provision for paid maternity leave. **We recommend that Ministers, when considering the resourcing of the maternity services, give urgent attention to filling these gaps in our knowledge of the true costs of the current pattern of delivery of maternity care.**

421. The announcement, in April 1991, of the appointment of Professor Michael Peckham as Director of Research and Development for the NHS[542] is, we believe, a hopeful sign in this respect. The objective of the NHS research and development strategy which he was appointed to implement is 'to ensure that the content and delivery of care in the NHS is based on high quality research relevant to improving the health of the nation',[543] and the Central Research Development Committee's terms of reference include advising on 'goals and objectives for work funded by the NHS in priority areas; evaluation of the outcomes of research programmes against these goals'; and 'methods of improving the utility and utilisation of research results'.[544] We are convinced that the maternity services should be a 'priority area' for such research, and that the achievement of the third objective cited above must be of the highest priority in this area. We trust this report will have gone some way towards identifying the 'goals and objectives' which should be set for the delivery of maternity services. These goals and objectives are not, by and large, in the glamorous areas of high level, high tech research, but in the area of 'soft outcomes' such as consumer satisfaction and the widely defined area of morbidity rather than mortality. We were heartened by Professor Peckham's recognition that 'The science of evaluation is an area of neglect between biomedical

[539]QQ800 ff
[540]Thirty-fifth Report from the Committee of Public Accounts, Session 1989-90, p. viii
[541]Cm 1323, p.11
[542]Official Report, 24 April 1991, c 474 w
[543]A Research and Development Strategy for the NHS, Department of Health, 1991, p 2
[544]ibid, p. 8

research and clinical practice'[545] and by the praise he heaped on the NPEU for its efforts to redress this neglect. We hope that by the time our successors come to follow up this report, the new managerial focus for research will have produced results, rather than more pious hopes.

The MRC and the NPEU

422. Our predecessor Committee, the Social Services Committee, in its 1980 report on Perinatal and Neonatal Mortality took much evidence on the subject of research.[546] They were told by Professor Alex Minkowski, a distinguished paediatrician from Paris that:

> "I do not know if Members of Parliament know that most of the basic knowledge we have in perinatology originates in this country [the UK]. Generally this is known abroad but perhaps not here".[547]

423. The Social Services Committee made seven recommendations relating to the preservation and encouragement of research, including that the MRC should give high priority to the funding of basic research in prenatal, perinatal and neonatal medicine; that the DHSS and MRC and other grant-awarding bodies should give high priority to research aimed at exploring the links between adverse socio-economic circumstances and perinatal mortality; and that support should be continued for the then newly established National Perinatal Epidemiology Unit at Oxford. These recommendations were broadly accepted by the Government.[548]

424. In its 1984 follow-up enquiry[549] the Social Services Committee found that funding of research was becoming very difficult and they recommended that the DHSS and UGC do everything possible to ensure that the MRC was in a position to support important research in the field.[550] Again, the Government was sympathetic to the Social Services Committee's recommendation.[551]

425. During our present enquiry, the MRC sent us details of relevant research that they were currently supporting.[552] We noted that a wide range of research was in progress and we particularly congratulate the MRC on its support for the randomised trial which has recently shown that folic acid supplementation reduces likelihood of recurrence of neural tube defect. We were concerned, however, to read in the MRC's Corporate Plan[553] that because of financial constraints a reduction in funding for research into reproduction and child health (as well as in many other areas) was planned. Given the burden on society of genetic and other illnesses that have their origin before or around the time of birth we think that these cuts in funding are unwise. **We recommend that funding for the MRC should be sufficient to support a full research programme relevant to the maternity services.**

426. The Department also provided us with some information about the research that it supports.[554] The largest single investment is in the National Perinatal Epidemiology Unit, directed by Dr Iain Chalmers in Oxford. We have already noted how Dr Chalmers and his colleagues have accumulated a massive amount of information highly relevant to the planning of the maternity services and to the appropriateness or otherwise of various medical and other interventions. The findings synthesised in *Effective Care in Pregnancy and Childbirth* have profoundly influenced our deliberations in this inquiry. Their work provides excellent value for money. We believe that if the type of information acquired by the NPEU had been readily available ten to twenty years ago, and acted upon, some of the undesirable developments in the maternity services to which we have drawn attention would not have taken place. **We strongly endorse the work of the National Perinatal Epidemiology Unit, and recommend that the Department and the MRC continue to provide appropriate support and that funding be guaranteed for sufficient time to ensure the recruitment and retention by the NPEU of high quality staff who are enabled to undertake with confidence relatively long-term research.**

427. At our visit to the NPEU, we were told that very little funding is available for midwifery research. Dr Chalmers expressed concern about this because he felt midwives "ask different

[545]The Lancet, 10 August 1991, p 367
[546]HC (1979-80) 663-I, Chapter 24
[547]Ev p133
[548]Cmnd 8084 pp 56-57
[549]HC (1983-84) 308
[550]ibid, para 83
[551]Cmnd 9371, pp 11-12
[552]MS91, 91A
[553]MRC, 1991, p22
[554]Ev pp 169, 175, 185, 194, 197

questions" and that such research is likely to be of benefit to future maternity care. We are persuaded that midwives have much to contribute to research and **we recommend that a midwifery research funding body, attached to the NPEU, be set up to enable the expansion of research by midwives.**

Statistics

428. We have, however, heard from the NPEU and several other witnesses that any attempt to evaluate the effectiveness of the maternity services is in danger of being vitiated by the poor state of data collection within the NHS and the registration service.

429. They emphasised to us the serious problems with information about in-patient stays in maternity units in England at the present time.[555] It was intended that HIPE should be replaced by the Maternity Hospital Episode system from September 1988 but this system is still not working properly. The most recent data contain records for only some 360,000 of the 653,871 births in England in 1989-90[556] and the data for 1990-91 are only slightly less incomplete.[557] Ms Karen Dunnell, head of the medical statistics division in OPCS, told us:

> "We have not produced any reports or carried out any analyses on (the data from the hospital episode statistics) since they began in 1986-87 because they are inadequate".[558]

430. Data from birth and death registration are in general complete and of good quality but the birth weight data collected have recently become seriously deficient. In 1988, 99.9 per cent of all births in England and Wales had birthweight recorded but by 1990 this had fallen to less than 96 per cent. This means that national data on the incidence of low birthweight are now unreliable. Low birthweight is the major factor associated with perinatal mortality and morbidity, and one of the most sensitive indicators of the health of the childbearing population, and as such is key data.

431. The recent registration White Paper[559] (published in January 1990) proposed legislation to lower the gestational age for registration of stillbirths to 24 weeks. This proposal has been picked up by Mrs Rosie Barnes MP in her Stillbirth (Definition) Bill currently going through Parliament. Unfortunately, this still does not meet the criteria set down by the World Health Organisation, and accepted by many other developed countries which is to include all babies weighing more than 500 grams in calculating stillbirth perinatal and infant mortality rates. This means that international comparison of the United Kingdom's stillbirth and perinatal mortality rates will remain problematic.

432. Professor Eva Alberman, Vice-chairman of the Medical Advisory Committee of the Medical Statistics Division of the Office of Population Censuses and Surveys (OPCS), told us:

> "We thought at first this (increase in the number of births for which we do not have birthweight) was a simple question of loss of information when there was a changeover (in the recording methods). It is clearly not quite as simple as that... I am certainly very concerned about it".[560]

433. A major concern is the persisting social class differences in perinatal mortality rates. However, with the growth of single parent families (in 1990, 28.3 per cent of births in England and Wales) social class data based only on fathers' occupations and births within marriage has become increasingly misleading. Ms Beverley Botting, statistician in the Medical Statistics Division of the OPCS, told us:

> "The traditional way of presenting statistics has been based on the father's occupation and deriving a social class based on that. We have from birth and death registration details of the father's occupation for babies born outside marriage where the father is present at the registration of the birth. If the mother has a child outside marriage and the father is not present at the birth registration we do not have any father's details. Since 1986 women have been asked at birth registration whether they wish their occupation to be recorded. At the moment it is still a voluntary question. We have been looking at the data over a time in terms of what proportion have had a mother's occupation given, and it is increasing, but we are still only talking of about 50 per cent overall. It tends to be a higher proportion of women in (the) higher

[555]MS50
[556]Official Report 10.6.91 col 446w
[557]Official Report 13.1.92 col 521-2w
[558]Q1344
[559]Cm 939
[560]Q1342

social classes who wish to give social class at birth registration. Therefore it is difficult to do analyses".[561]

Mrs Mary Tyler wrote to us after hearing this evidence:

"I would also strongly support those who were stressing that early mortality statistics are not only important in themselves, but they also provide an indicator for the groups most likely to be affected by various forms of handicap: these include probable later ill-health and educational disadvantage".[562]

434. Our witnesses from OPCS also highlighted the paucity of national information relating to the antecedents of handicap, particularly in relation to follow-up of babies who have been treated in neonatal intensive care units.[563] This point was emphasised to us in a memorandum submitted to us by Drs Johnson, Mutch and Morley.[564] They stated:

"Since 1980 there has been a commitment by government to develop routine data collection systems including information on childhood morbidity. Unfortunately these systems are not yet fully in place, so uncertainty persists about the long term status of children who survive after periods of expensive, intensive neonatal care. (However) studies using geographically defined population registers of children with cerebral palsy have provided some evidence that the rate of cerebral palsy may be rising among children who weighed less than 1500g at birth. It is a worrying trend which needs continued monitoring by those who maintain ongoing population registers of children with cerebral palsy. We believe that any country which invests in neonatal intensive care has an equal duty to make provision for monitoring the later health and well-being of children who have had such care".

435. We have had much evidence presented to the Committee which suggests that women want to know the policies of the maternity units to which they are referred, especially in relation to intervention in labour. They can only judge the effects of these policies by being informed about the prevailing rates of intervention in that unit. **We therefore recommend that all maternity services be obliged to publish figures relating to operative intervention and stillbirth and neonatal mortality rates over the previous five years, and to make these figures available to women booking with that service. We further recommend that all hospitals and birth attendants elsewhere contribute data in the Korner set to the Maternity Hospital Episode System, and consider collecting data in the maternity and neonatal clinical option.** When women have the information with which to make a truly 'informed' choice, the effect of their voting with their feet may make the providers of maternity services recognise failures to respond to women's wishes.

436. However, we accept that there are major problems in interpreting these figures. They are only interpretable in relation to factors known to be associated with intervention and mortality rates, notably social class, marital and household status at registration and the birthweight distribution of babies being born in each individual unit. **We therefore recommend that systems for collecting birthweights of all babies born weighing more than 500 grams be made effective as soon as possible, both on a local and a national level, and that demographic information and statistics about birthweight and social class tabulated according to local place of delivery and health authority of residence be made widely available.** Continuing public debate about such matters as the preferred place and circumstances for delivery cannot be meaningful without such information.

Recent initiatives

437. Two initiatives in the field of audit were announced by the Government during this inquiry. The first of these was the establishment of a Confidential Inquiry into Stillbirths and Perinatal Deaths.[565] This will be an important effort to establish best practice in the acute end of the maternity services. While we welcome the initiative, we are concerned that the necessary resources are still not in place to enable this inquiry to be effective. We have discussed our concerns about the regional perinatal pathology services in Chapter IV, and we made our recommendations about the steps necessary to ensure the success of the confidential inquiry there.

438. The other development is the establishment of the Clinical Standards Advisory Group. Part of its initial remit will be to look at the care of women during normal labour. We welcome this initiative, and look forward to the results of the Group's deliberations.

[561]Q1350
[562]MS408A
[563]Q1375
[564]MS176
[565]Q1515

Piloting and evaluation

439. In this report we have made recommendations which we trust will result, in due course, in a very different pattern in the delivery of maternity services in this country. We have identified above the requirements needed to ensure that we have the ability effectively to judge the outcome of the way in which we deliver those services, and we have had frequent occasion to criticise the lack of evaluation and audit of past patterns of care. The maternity services of the future which we propose must be rigorously evaluated against all the criteria which we have enunciated: satisfaction of women and their families; long and short-term morbidity in mothers and their babies; the meeting of health care targets; the effective utilisation of the skills of all the professionals involved; as well as mortality rates.

440. If, as we hope and expect, more births in future will take place outside consultant obstetric units, whether in peripheral units, midwife-managed units or at home, we must be able to assess confidently the outcomes of this change. Before we move too far in any new direction, effective and impartial evaluation must be undertaken of our proposals. To this end, **we recommend as a matter of priority, that the Department of Health funds the establishment of extensive pilot schemes in the establishment of midwife-managed maternity units within or adjacent to acute hospitals. We further recommend funding of an extensive programme of establishing small-team midwifery care using community-based clinics.** We believe that the latter development may lead to a significant increase in the number of home-births which will make it possible to obtain the data for a meaningful appraisal of outcomes in such circumstances. It will be particularly important, having taken full account of the factors which influence measurements in such circumstances, to make a full appraisal of benefits associated with a new distribution of place of birth or any risks arising from an increased level of transfers. **We recommend that the necessary evaluation programmes be put in place promptly.**

Feedback

441. We have placed women at the centre of this inquiry and report. We have recommended that they must be placed at the centre of the maternity services of the future. It will be necessary to ensure that they remain there. This inquiry has demonstrated the great need for quality control and feedback from consumers in ensuring that the maternity services are meeting their targets.

442. There is little to be gained by giving women more information, choice and control in their experience of the maternity services if, when things go wrong, they are frustrated in their attempts to utilise these tools and consequently feel disempowered. Many women are currently deterred from complaining by procedures which are insufficiently publicised, intimidating, fragmented and biased in favour of the professionals. An accessible, independent, speedy and responsive complaints system will not only give women the confidence to pursue the type of care they prefer, but will also provide them with an explanation, apology or compensation where appropriate. It will also help to ensure that improvements in the service are made.

443. We have discussed the perceived shortcomings of the current complaints procedures elsewhere in this report. One of the key issues which we identified as preventing its effectiveness is the same issue of continuity that has arisen again and again in this inquiry. Maternity care should be seamless, and the complaints procedure should reflect this.

444. We suspect that the current complaints system is failing not only women using the maternity services, but users of the health services as a whole and therefore the system requires fundamental review. We hope that the Health Committee in the next Parliament will give consideration to looking in more detail at the NHS complaints procedures as a whole.

445. **We recommend that the Government strengthens the role of Maternity Services Liaison Committees (MSLCs), which have the potential at local level to channel more effectively users' views into the planning and monitoring stages of service delivery. This can be achieved in part by increasing the lay membership on MSLCs and developing a mechanism to ensure that the committees are an integral part of the planning process. To assist the different professional groups in working co-operatively at local level, we recommend that the Chair of these committees be held by a member independent of the professional groups principally involved in providing maternity care. As part of purchasing authorities' work in developing systems of clinical audit and quality assurance, we recommend that MSLCs establish systems to elicit and review comments from users of maternity services, including (anonymised) complaints that have been received, and feed these into the monitoring process.**

Litigation

446. We are persuaded that the inadequacies of the complaints procedures combined with the wider sense among users that they have little opportunity to influence the development of maternity services are, at least in part, responsible for the mounting level of litigation in the field of obstetric care. Litigation is also more likely in a depersonalised care delivery system, where parents have little sympathy with the professionals caring for them because they never get to know them. This is yet another area where continuity of care may have beneficial effects. The unsupervised actions of excessively tired junior medical staff are also a common source of litigation, as we have described earlier.

447. The special problems of litigation in obstetrics stem not only from these factors, but also from the universal applicability of legal aid to damaged infants as by definition they have no income together with the prolonged period of liability and the massive sums awarded to cover a lifetime of disability.[566] Such awards are threatening to erode the resources available for maternity care. On the estimates given by the Chief Medical Officer Sir Donald Acheson, in his William Power memorial lecture in 1990, a district where 2,500 women per year gave birth might in future have to pay £2,000,000 a year in legal awards and expenses[567] (almost 50 per cent of current total budgets).

448. In our opinion, no-fault compensation might reduce the number of awards, but would still leave the problem of accountability for mistakes and how to prevent them recurring. It would also fail to address the problem of equity, for only a small proportion of longterm handicap can be attributed to medical or midwifery error.[568] Thus even a no-fault system of compensation would only ameliorate the lot of a small fraction of children needing special provision. **We therefore recommend a four pronged attack on the problem of litigation by:**

- **Improving education of maternity care givers so as to minimise the errors which promote litigation.**
- **Improving the complaints procedure so that parents do not feel the need to resort to litigation so as to "punish" the staff concerned.**
- **Improving continuity of care so that women come to know their care-givers as people who, being human, are prone to error without implying malice, and can accept that accidents can never be completely prevented.**
- **Improving care for disabled children and adults so that multi-million pound settlements are not seen as the only way to ensure their longterm protection.**

Resources

449. Because of shortcomings in the data, and the large gaps in the Department of Health's knowledge about the costs of different elements of maternity care, it has not proved possible for the Committee in this inquiry to identify with any degree of accuracy the overall resource implications of the recommendations it has made. What is quite clear to us, so far as the maternity services of the NHS are concerned, is that resources are not being used to their best effect. There are approximately twenty births per year in the UK for every registered midwife. Yet this valuable and expensive resource is so inefficiently applied that we still fail to give women what they want from the maternity services. The obstetric specialty is understaffed and overworked and unable to give those women who need special care during pregnancy and birth the attention they deserve. In order to be paid for giving the health care to mothers and their families which they need at this critical time, general practitioners are required to impose a pattern of service provision which often fails to meet the needs of women and which fails to utilise the resources of midwives either efficiently or effectively.

450. Women in this country have been deprived of effective choice about where they give birth. Small maternity units have been closed because health authorities have decided, without pausing to consider the evidence too closely, that these are unsafe, expensive or both. They have then set about ensuring that they become more expensive by introducing policies designed to reduce their use further.

451. Too many women are subject to expensive interventions which they should not need and do not want. Some of them are useless. At the same time, some dangerously ill babies are denied access to the intensive care they need because resources and sufficient trained staff are unavailable.

[566]Clements, R.V. Litigation in obstetrics and gynaecology. British Journal of Obstetrics and Gynaecology 98 423-426
[567]Ev. p 146, para 10.1
[568]see footnote 419

Meanwhile, healthy women experiencing normal pregnancies, labours and deliveries are denied the use of the resources of their own bodies, homes and families and are thereby forced to deplete the resources of an overstretched health service. To meet the needs we have identified in this report need not necessarily, we believe, require more overall resources. It will require imagination, flexibility, and a readiness to listen to what mothers and mothers-to-be are asking for.

Conclusion

452. We have found much to criticise about the present delivery of maternity services. For this, some blame must attach to all the professionals involved: medical, midwifery and management. Politicians and civil servants must also shoulder some of the responsibility for the failures we have identified. However, we believe that there are enormous resources of goodwill, skill and commitment to be drawn upon in taking the maternity services forward into the future. All of us have reason to be grateful to the midwives who have helped bring so many millions into this world in happy circumstances. Many hundreds of thousands of us have reason to be grateful for the skill of obstetricians and paediatricians in saving the lives of mothers and babies. All this is achieved in this country at relatively little cost when compared to the rest of the developed world. We believe that to achieve the maternity services which we wish to see in the future will require that those who control and manage the resources of the maternity services, and those who provide those services, acknowledge their users as full partners. They must then engage in a dialogue to achieve a proper balance between the goals and objectives set and the resources which are available to meet them.

453. Above all, it requires an affirmation that the needs of mothers and babies are placed at the centre, from which it follows that the maternity services must be fashioned around them and not the other way round.

LIST OF RECOMMENDATIONS AND CONCLUSIONS

On the basis of what we have heard, this Committee must draw the conclusion that the policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety. (Para 33)

Given the absence of conclusive evidence, it is no longer acceptable that the pattern of maternity care provision should be driven by presumptions about the applicability of a medical model of care based on unproven assertions. (Para 33)

We conclude that there is a strong desire among women for the provision of continuity of care and carer throughout pregnancy and childbirth, and that the majority of them regard midwives as the group best placed and equipped to provide this. (Para 49)

We conclude that there is a widespread demand among women for greater choice in the type of maternity care they receive, and that the present structure of the maternity services frustrates, rather than facilitates, those who wish to exercise this choice. (Para 52)

We recommend that information about linkworkers be obtained and evaluated. (Para 69)

We conclude that many women at present feel that they are denied access to information in the ante-natal period which would enable them to make truly informed choices about their care, their carer and their place of birth. They are unnecessarily deprived of access to their medical notes. Too often bad news is given in an unsympathetic way. Too often they experience an unwillingness on the part of professionals to treat them as equal partners in making decisions about the birth of their child. (Para 73)

We conclude that the choices of a home birth or birth in small maternity units are options which have substantially been withdrawn from the majority of women in this country. For most women there is no choice. This does not appear to be in accordance with their wishes. (Para 86)

We conclude that until such time as there is more detailed and accurate research about such interventions as epidurals, episiotomies, caesarian sections, electronic fetal monitoring, instrumental delivery and induction of labour, women need to be given a choice on the basis of existing information rather than having to undergo such interventions as routine. (Para 96)

We conclude that there is a need to establish methods of monitoring levels of significant postnatal maternal infection to ascertain the extent of this problem and whether it is growing. (Para 99)

We conclude that the experience of the hospital environment too often deters women from asserting control over their own bodies and too often leaves them feeling that, in retrospect, they have not had the best labour and delivery they could have hoped for. (Para 100)

Whichever feeding method a mother chooses to adopt she needs advance information and support to enable her to establish the method of her choice, and she needs expert advice and strong support after birth until she is confident about her chosen method of feeding. (Para 108)

We recommend that the guidelines drawn up by SANDS should form the basis for training of all professionals and managers involved in maternity care for dealing with bereavement. All units should ensure that such training is given to staff in a properly designed way. (Para 116)

We commend the publication by the Stillbirth and Neonatal Death Society "A Dignified Ending" to all hospitals. (Para 117)

We conclude that the evidence highlighted the overarching need for professionals to take account of best practice and to formulate coherent and sensitive policies to address the needs of parents and families who experience miscarriage, stillbirth and neonatal death. (Para 120)

We conclude that the Department of Social Security cannot comment with authority on the adequacy of Income Support rates for providing a balanced diet for pregnant women in the absence of research to support its view. We therefore recommend that the Department of Health and the Department of Social Security conduct research specifically into the food purchasing and food consumption patterns of pregnant women in receipt of Income Support. (Para 133)

We conclude that to compound the risks to very young mothers with the setting of benefit levels on the assumption that where teenage women are pregnant family and friends will in all cases provide support for the young woman is putting such mothers and babies at further unnecessary

risk. We recommend that pregnant 18–24 year olds who qualify for Income Support should receive it at the full adult rate. (Para 137)

We recommend that where 16 and 17 year olds qualify for income suport, either under the normal rules or under the severe hardship arrangements, benefit should be paid at the full adult rate. Where a 16 or 17 year old is on Youth Training, then the allowance should be increased to equal full adult rate Income Support. We can see no reason for a policy to discriminate against pregnant women on grounds of age, and we do not believe that this was the original intention of the Government. (Para 141)

We recommend that the DSS conduct research into the contribution to the costs of maternity made by the Social Fund maternity payment. (Para 144)

We recommend that the DSS and Department of Health review their benefit arrangements to ensure that local offices can take full account of the special needs of families which have experienced multiple births. (Para 145)

We recommend that the Department of Social Security review urgently all the terms and qualifications for Statutory Maternity Pay with a view to addressing the problems which we have identified. (Para 149)

We recommend that the position of women working in low paid jobs be evaluated to determine whether Family Credit should be extended into pregnancy. (Para 150)

We conclude that maternity leave is significantly a matter of public health—it should not be overlooked that the health of the unborn or new born child is also at stake. (Para 156)

We conclude that the complaints system is failing to achieve the purpose for which it was designed, at least so far as the maternity services are concerned. This failure may be causing earlier and more frequent recourse to litigation which is itself undesirable. (Para 162)

We conclude that, at present, Maternity Services Liaison Committees are failing to provide women using the maternity services with a fully effective channel to influence the shape of provision of those services. (Para 171)

We conclude that there is a need for: well-designed and appropriate levels of maternity benefits; the provision of information in appropriate forms and languages on the options available at every stage of care; the provision of linkworker and advocacy schemes where required; the opportunity whenever possible for women to remain in the hospital or unit until sufficient social support is available on discharge; and the training of staff in counselling skills and awareness of the special requirements of different groups of women. Moreover, the complaints procedure requires a thorough review if it is to provide users of maternity services with an effective mechanism for gaining emotional, practical or financial redress. (Para 174)

The evidence we have received suggests that the importance of continuity of care needs underlining very heavily for the professionals who are involved in delivering the maternity services of the NHS. Many still demonstrate an insufficient awareness of its prominence among the criteria which women use to judge the quality of the care they have received. Nor have they yet done nearly enough to respond in practical terms to the call by women to be involved as full partners in the decisions made about their care. (Para 191)

We believe that the discussions we have heard about the case of providing continuity of care and the enabling of women to control their own pregnancies and deliveries have been far too heavily influenced by territorial disputes between the professionals concerned for control of the women whom they are supposed to be helping. (Para 191)

We are persuaded that the present imposition of a rigid pattern of frequent antenatal visits is not grounded in any good scientific base, and that there is no evidence that such a pattern is medically necessary. The identified needs of women for information and support during pregnancy can be met more effectively than happens at present. There is widespread agreement that this requires a more flexible system which is based in the community, not in the hospital. The present system of shared care between hospitals and the community should, by and large, be abandoned. Hospitals are not the appropriate place to care for healthy women. (Para 208)

We conclude that there is a broad consensus among the professionals that the development of day care obstetric assessment units in hospitals, combined with community-based antenatal care, would allow for rapid referral of antenatal women for further investigations and specialist opinion. (Para 218)

We conclude that the desirable development of community-based antenatal care, combined with ready access to specialist assessment, will best be advanced by the general acceptance of the right of midwives to refer women directly to obstetricians or other appropriate specialists. Systems to ensure the prompt notification of GPs of such referrals will be necessary. Continuity of care in these circumstances is likely to be facilitated by encouraging women to hold their own notes. (Para 219)

We conclude that there is an established need for the professionals involved in the maternity services to address the issue of providing women with a wider choice of place of birth and to consider ways of organising services to support that choice. More immediately, there is a need to establish ways of providing a choice of a less medicalised pattern of intrapartum care, whatever the setting. (Para 230)

We are not persuaded by the evidence we have received that the current organisation of the maternity services for intrapartum care has yet succeeded in resolving conflicts between different philosophies of care. In the oral evidence presented to us there was a clear indication of the potential for a damaging demarcation dispute between the professional groups over how labour should be supervised. We believe that there is an urgent necessity for the NHS and the Royal Colleges to address and resolve this dispute. (Para 232)

We recommend that every community midwife, obstetrician, paediatrician, general practitioner and hospital midwife in the United Kingdom should be supplied with a copy of the NPEU's "Effective Care in Pregnancy and Childbirth". (Para 237)

There appears to be no reason why the midwife should not carry out the routine examination of apparently healthy newborn infants, provided she is well trained in the detection of congenital abnormalities and the subtle signs of impending illness. (Para 239)

We recommend that protocols are drawn up by every District Health Authority and Health Board to ensure the rapid referral of babies becoming ill at home and requiring specialised attention. To facilitate this, the midwife should be able to refer directly to the paediatrician, while also notifying the GP of such referrals. (Para 243)

We concur with the RCM that the policy of reducing the length of lying-in for mothers in hospital merits very close examination in respect of its effect on maternal morbidity. We also recommend that the freedom of women to determine their length of stay, in consultation with midwives and doctors and within sensible limits, should be unequivocally stated by the Department of Health and promulgated to all hospitals. (Para 250)

We conclude that there is universal agreement between all involved in maternity care that an increase in the level of breastfeeding is desirable. We note that steps have been taken in some areas to focus upon developing this skill among midwives. We recommend that all midwife managers establish targets against which to measure the success of midwives in supporting breastfeeding among those women choosing to try to breastfeed their baby; that these targets should be challenging; and that the training and resources required to meet them be identified. (Para 255)

It is clear to us from the evidence of the professions that postnatal care, like other aspects of the maternity services, is poorly evaluated and researched, delivered in often inappropriate and fragmented ways and has a dissipated managerial focus which militates against efficient use of resources. (Para 257)

We conclude that the establishment of transitional care facilities within postnatal wards offers a very welcome development towards providing care in appropriate cases which resembles as closely as possible that provided for healthy babies. (Para 259)

We recommend an urgent review of staffing and resources in postnatal wards, to ensure that babies needing transitional but not special or intensive care can remain with their mothers, be undertaken by all MSLCs in conjunction with the NNA, the RCM and the BAPM. Sufficient midwives should be made available to allow an increase in transitional care, thus releasing cots in neonatal units. We believe that the targeting of appropriate care to all three levels of neonatal need, whilst it may not entirely address the problem of insufficient intensive care facilities, can only help to relieve the problem. (Para 262)

We recommend that sufficient provision of medical and nursing support in the community be made available so that the early discharge home of babies from special care units can be encouraged. (Para 263)

We conclude that it is manifestly wrong that ill babies requiring intensive care should be refused admission, or that twins or higher order births should have to be sent to different hospitals, because of lack of sufficient intensive care cots. We reiterate the recommendation of the Social Services

Committee that data on the number and type of cots available and the number of and reasons for refusals of babies for care in them should be collected and that the correct level of provision be established and put in place. (Para 275)

We conclude that little progress has been made in the establishment of a satisfactory regional service for perinatal pathology since the Social Services Committee made its first recommendations on the subject in 1980. We do not see how the Government's initiative to find out why particular babies die, can be carried out unless a proper service is in place. We recommend that an immediate survey be done to define the number of perinatal pathologists in post, that the necessary number be agreed between the Department and the professional bodies (the RCPath and BPPA), and that this number be established as soon as possible. (Para 287)

We recommend that geographically-based follow-up of intensive-care survivors, especially VLBW infants, should be regionally organised and supervised by Regional Perinatal Advisory Committees. The results should be made widely available so that the outcome of intensive care is clearly known. (Para 290)

We are not persuaded that the establishment of contracts for regional services for perinatal and neonatal intensive care can be left to market forces and audit. (Para 300)

In order to safeguard regional perinatal and neonatal services, we recommmend:

—the establishment of Regional Perinatal Advisory Committees (RPACs) to plan and supervise the regional services;

—Regional contracts, if possible, or failing that district contracts that be placed only in units accredited by the RPACs, and which are sensitive to the work actually done;

—Freedom should be retained for mothers whose babies in utero are at very high risk and for babies requiring intensive care to be treated as emergency extracontractual referrals. (Para 302)

We recommend that, in order to ensure the success of the Confidential Enquiry into Stillbirths and Neonatal Deaths, means must be found for preserving the funding of regional services for perinatal pathology where these exist, and funds provided for setting them up where they do not. We are again concerned that such highly specialised provision should be left solely to the operation of the internal market at this very early stage of its introduction, and we recommend a system of top-sliced funding to ensure the creation of an effective perinatal and paediatric pathology service. (Para 303)

At present reforms of the NHS are being put into effect which may have far-reaching consequences on its organisation and structure. We believe that it is vital to ensure that, during this period of change, the regional specialties are protected. (Para 304)

We concur with the Minister of Health that the time has come for a shift in emphasis in the development of policy for the maternity services which gives due weight to other criteria for success additional to the reduction of perinatal mortality. To achieve that shift in emphasis will, we believe, require energy, determination and leadership at all levels of the National Health Service and within the Department of Health, as well as among the representative institutions of the professions involved in the maternity services, to enable them to assess and then to meet the widely expressed wishes of women and their families for a different approach. It will not come about by mere wishing. (Para 307)

We recommend a radical reappraisal of the current system of shared care with a presumption in favour of its abandonment. (Para 309)

We recommend that the policy of closing small rural maternity units on presumptive grounds of safety be abandoned forthwith. We further recommend that no decision be taken to close such a unit unless it can be explicitly and incontrovertibly demonstrated that they are failing to provide value for money, and that the costs to consumers are fully taken into account in making such calculations. We recommend that in considering any appeal against the closure of such a unit, the Secretary of State should make a presumption against closure unless the case is overwhelming, since we believe that there is a shift in attitude towards maternity care which can only be met by maintaining such units as a realistically available option. (Para 312)

We recommend that a study be funded by the Department to consider all aspects of the work of neighbourhood maternity units in the Bath HA, and that it be designed not only to reassess the issues of safety and cost, but also to take account of the other criteria we have identified in this report for defining success in the delivery of maternity care. (Para 313)

We recommend the development of paramedic training in ambulance aid, emergency obstetrics and gynaecology and the provision of appropriately equipped ambulances in all areas. (Para 318)

We recommend that MSLCs should be required to develop effective emergency arrangements for the resuscitation of mothers and babies in all areas. (Para 318)

We recommend that the development of midwifery-managed maternity units, combined with effective continuity of midwife care between the community and hospital, should be pursued by all DHAs. (Para 324)

We recommend that all hospitals (including Trusts) write into their expenditure programmes sufficient funds to continue the process of humanising and maintaining in good condition their maternity units. (Para 326)

We recommend that all hospitals make it their policy to make full provision whenever possible for women to choose the position which they prefer for labour and birth with the option of a birthing pool where this is practicable. (Para 327)

We recommend that a hospital delivery unit should:

— afford privacy;

— look like a normal room rather than be reminiscent of an operating theatre;

— enable refreshments to be available for the woman and her partner or companions;

— ensure the feasibility of the woman being "in control" of her labour. All case notes should contain the women's wishes for her labour;

— enable the woman to take up those positions in which she is most comfortable;

— enable the woman to have with her a midwife she has been able to form a relationship with during her pregnancy. (Para 328)

We recommend that neonatal units should be designed with the needs of parents and staff, as well as babies, in mind; and that accommodation should be provided for parents to live-in when required. Mothers of babies transferred from other hospitals should be moved as soon as feasible to the hospital treating their baby. Maximum support for all parents and family members should be available from doctors, nurses, religious and other counsellors and all those who work in the unit. (Para 330)

We recommend that the proposals of the Northern Ireland Department of Health and Social Services contained in circular A585/91, issued in August 1991, be withdrawn and reconsidered. (Para 338)

We recommend that the Department vigorously pursue the establishment of best practice models of team midwifery care. We believe that as well as research this will require the allocation of pump priming money to fund the transitional costs of moving to a new pattern of service. There is no evidence to suggest that such a pattern of care must be more expensive overall than at present, and we are convinced that it will provide better value for money. (Para 339)

We recommend:

— that the status of midwives as professionals is acknowledged in their terms and conditions of employment which should be based on the presumption that they have a right to develop and audit their own professional standards;

— that we should move as rapidly as possible towards a situation in which midwives have their own caseload, and take full responsibility for the women who are under their care;

— that midwives should be given the opportunity to establish and run midwife managed maternity units within and outside hospitals;

— that the right of midwives to admit women to NHS hospitals should be made explicit. (Para 344)

We believe that it is the system of item-of-service payments to general practitioners for maternity care, as presently operated, which drives the pattern of service delivery in an inappropriate fashion and we recommend that it is abandoned and redesigned, starting with a focus on care targets rather than the remuneration of GPs. (Para 347)

We recommend that any new system of remuneration of GPs for maternity care should be very heavily weighted towards rewarding those who provide intrapartum care and therefore that continuity of care which is so crucial. (Para 348)

We recommend that different options for the payment of GPs for maternity care be urgently considered with a view to revising the GP contract. (Para 348)

We recommend that the Department of Health take steps to impress upon all GPs their duty to facilitate the wishes of women, especially in respect of their choice of place of birth and their right to midwifery only care. FHSAs should also take steps to impress upon all GP practices that it is wrong to remove a woman from their list solely because they wish to have a home confinement, or midwifery-only care, and we recommend appropriate safeguards to prevent this. (Para 349)

We recommend that it be a duty placed upon all GP practices to have in place arrangements for women to have a home confinement with GP cover or midwife-only cover if they so desire. (Para 349)

We recommend that no decision be taken on the extension of the power to purchase maternity services to GP Fundholders until the Government's response to this Report has been published and sufficient time has elapsed to allow full consultation on it to take place. (Para 350)

We recommend that maternity units should be required by purchasing authorities to make explicit their arrangements for senior medical staff availability for intrapartum care in abnormal labours. (Para 363)

We recommend that senior house officers should function as trainees, with principal responsibility for normal labours being taken by midwives. Abnormalities in labour should be dealt with by registrars who should always have the option of direct supervision by trained obstetricians (at senior registrar or consultant level). (Para 364)

We recommend that factors that should be evaluated in practice and that the number of consultant posts be increased where and when a specific need is established. We also recommend that the criterion for evaluating practices and costs should always be: will it result in a "health gain". (Para 366)

We therefore recommend that, in determining the appropriate level of medical cover for any maternity service, a priority must be the need to allow for the adequate availability of senior medical staff for duties, emergency or otherwise, on the labour ward. (Para 367)

We recommend that the Royal College of Obstetricians and Gynaecologists, in consultation with the NHS management, explore the possibility of developing, where appropriate, obstetrics only consultant posts and academic posts within teaching hospitals. It may also be appropriate for some posts to be gynaecology only. (Para 368)

We recommend that the Department of Health take positive steps to accelerate the rate of implemetation of reduced hours of work for junior medical staff in obstetrics, to no more than 72 hours per week. Moreover, the Department should encourage the investigation of new working practices, such as shift work, part time working, and job shares, which will make pursuing a career in obstetrics and gynaecology more compatible with a normal family life. (Para 373)

We recommend that consideration is given to arranging two year rotations within a local geographical area, to enhance job security. Further, we recommend that formal arrangements for funding maternity and study leave be reviewed and brought up to the best EC practice. (Para 373)

We recommend that the medical staffing levels recommended by the Royal College of Physicians, the British Paediatric Association, and the British Association of Perinatal Medicine for the provision of care for newborn infants in regional and subregional perinatal centres, for the care of babies in special care units and for the supervision of normal babies be adopted as a target to be achieved as soon as possible, and in any case not later than 1995. (Para 377)

We recommend that:

—The appropriate staffing levels for nurses in regional neonatal intensive care units as defined by the NNA be adopted as the norm and included in guidelines for accreditation of regional units.

—Proper support by ancillary staff should be provided in neonatal units.

—Adequate recognition of the stressful nature of the work in neonatal intensive care units—with proper time off, and study leave, should be ensured. (Para 379)

We recommend that the research conducted in the Grampian Region into postnatal care be broadened and conducted in selected areas of England. (Para 383)

We recommend that, in redesigning postnatal services, the need for continuity of care be placed at the centre. (Para 383)

We recommend that, in the area of postnatal care above all others, attention must be turned away from a medical model of care to a woman-centred approach which takes full account of their social needs. (Para 383)

We summarise the broad principles of our recommendations relating to maternity care as follows:

—That the relationship between the woman and her care-givers is recognised as being of fundamental importance.

—That schemes should be set up enabling women to get to know one or two health professionals during pregnancy who will be with them during labour and delivery, whether at home or in hospital, and who will continue the care of the mother and baby after birth.

—That the majority of maternity care should be community based and near to the woman's home; and that obstetric and other specialist care should be readily available by referral from midwives or GPs.

—That those GPs who wish to provide a continuum of care throughout pregnancy, labour and the puerperium should be able to do so; and that their training should equip them to do so.

—That women needing intensive obstetric care within the NHS should also be able to enjoy continuity of care and carer, so far as is possible.

—That within a hospital women should be able to exercise choice as to the personnel who will be responsible for their care.

—That the woman having a baby should be seen as the focus of care; and that the professionals providing that care should identify their needs and develop arrangements to meet them which are based on full and equal co-operation between all those charged with her care.

—That proper attention should be paid to the needs of the baby, with particular regard to skilled resuscitation at birth, examination for abnormalities, and the encouragement of breastfeeding. (Para 384)

We remain firmly convinced that the pattern of provision of special care and intensive care for babies that grew in part from the recommendations of the Report of the Social Services Committee in 1980 remains the most appropriate and effective system of provision. (Para 385)

We recommend that NHS Management Executive be directed to establish a forum, modelled upon the Welsh Health Planning Forum, charged with the specific duty of preparing a national protocol which identifies the targets of the maternity services in terms of health care, and with the purpose of requiring health service purchasers to produce specific plans for meeting those targets. The key to achieving such targets will, we believe, be a radical reconsideration of the deployment of human and financial resources. (Para 394)

We believe, in the light of this inquiry, that the publications of the Maternity Services Advisory Committee of almost ten years ago are superseded. We recommend that they be withdrawn and replaced by the publication of the forum whose establishment we have recommended above. (Para 395)

We recommend that an urgent review of training needs for senior house officers be undertaken. We further recommend that the RCGP and the RCM be invited to participate in the review, and that any training programme devised contain at least a half-day of formal instruction per week. That instruction should be shared between obstetricians, midwives and general practitioners, and paediatricians should be involved in instruction about the newborn. Training at senior house officer level should concentrate on the normal, and those aspects of abnormality capable of being dealt with at general practitioner level. (Para 405)

We recommend that the RCOG and the NHS Management Executive jointly review both the length and content of obstetric training. We further recommend that at the completion of training, when doctors become accredited, their employment should reflect their status as fully-trained independent practitioners. (Para 407)

We would recommend that all those who are involved in the provision of statutory periodic refresher courses and in-service up-dating for midwives base a substantial element of future courses upon the presumption that midwives will be working rapidly towards the recommendations of this Report. (Para 410)

We recommend that the training of midwives and GPs in the resuscitation of newborn babies should enable them, so far as possible, to keep babies which fail to breath alive and in good condition until such time as skilled assistance is available. This will require constant in-service training and retraining, and the resources necessary to provide this. Wherever possible, we recommend that a second pair of hands should be available, in case the mother and baby need attention at the same time. (Para. 414)

We recommend that the United Kingdom Central Council instigate a review of the training needs of midwives in neonatal examination and resuscitation as a matter of urgency in collaboration with the British Paediatric Association. (Para 415)

We recommend that midwives should be afforded the same rights as all other professions over the control of their education. Whether in NHS or other institutions, midwifery studies should be afforded independent faculty status. Selection of candidates, curriculum planning, assessment processes and course validation must remain under the control of the midwifery profession. We would expect these principles to be upheld not only in the training establishments but also by the statutory bodies that set overall national standards for training and approve and monitor the courses. (Para 417)

We recommend that Ministers, when considering the resourcing of the maternity services, give urgent attention to filling gaps in our knowledge of the true costs of the current pattern of delivery of maternity care. (Para 420)

We recommend that funding for the MRC should be sufficient to support a full research programme relevant to the maternity services. (Para 425)

We strongly endorse the work of the National Perinatal Epidemiology Unit, and recommend that the Department and the MRC continue to provide appropriate support and that funding be guaranteed for sufficient time to ensure the recruitment and retention by the NPEU of high quality staff who are enabled to undertake with confidence relatively long-term research. (Para 426)

We recommend that a midwifery research funding body, attached to the NPEU, be set up to enable the expansion of research by midwives. (Para 427)

We recommend that all maternity services be obliged to publish figures relating to operative intervention and stillbirth and neonatal mortality rates over the previous five years, and to make these figures available to women booking with that service. We further recommend that all hospitals and birth attendants elsewhere contribute data in the Korner set to the Maternity Hospital Episode System, and consider collecting data in the maternity and neonatal clinical option. (Para 435)

We recommend that systems for collecting birthweights of all babies born weighing more than 500 grams be made effective as soon as possible, both on a local and a national level, and that demographic information and statistics about birthweight and social class tabulated according to local place of delivery and health authority of residence be made widely available. (Para 436)

We recommend as a matter of priority, that the Department of Health funds the establishment of extensive pilot schemes in the establishment of midwife-managed maternity units within or adjacent to acute hospitals. We further recommend funding of an extensive programme of establishing small-team midwifery care using community-based clinics. (Para 440)

We recommend that the necessary evaluation programmes to make a full appraisal of benefits associated with a new distribution of place of birth or any risks arising from an increased level of transfers be put in place promptly. (Para 440)

We recommend that the Government strengthens the role of Maternity Services Liaison Committees (MSLCs), which have the potential at local level to channel more effectively users' views into the planning and monitoring stages of service delivery. This can be achieved in part by increasing the lay membership on MSLCs and developing a mechanism to ensure that the committees are an integral part of the planning process. To assist the different professional groups in working co-operatively at local level, we recommend that the Chair of these committees be held by a member independent of the professional groups principally involved in providing maternity care. As part of purchasing authorities' work in developing systems of clinical audit and quality assurance, we recommend that MSLCs establish systems to elicit and review comments from users of maternity services, including (anonymised) complaints that have been received, and feed these into the monitoring process. (Para 445)

We recommend a four-pronged attack on the problem of litigation by:

- Improving education of maternity care-givers so as to minimise the errors which promote litigation.
- Improving the complaints procedure so that parents do not feel the need to resort to litigation so as to "punish" the staff concerned.
- Improving continuity of care so that women come to know their care-givers as people who, being human, are prone to error without implying malice, and can accept that accidents can never be completely prevented.
- Improving care for disabled children and adults so that multi-million pound settlements are not seen as the only way to ensure their long-term protection. (Para 448)

APPENDIX 1

The following visits and meetings in the United Kingdom and abroad were underaken by the Commitee in connection with the inquiry:

The Committee would like to express its gratitude to all orgnisations and individuals visited for the time and effort taken to enable Members to see and learn as much as possible in a short space of time, and for the hospitality extended.

London, (Pimlico and Hammersmith), 14 May 1991

1. Bessborough Street Clinic:

   Community midwifery service, set up after closure of maternity services at Westminster Hospital and in response to demands from local women.

2. West London Hospital:

   Instituted a team approach to care. Hospital based teams cover defined geographical areas. Consultants attached to, not in charge of, these teams.

3. Queen Charlotte's and Chelsea Hospital:

   Provides majority of local obstetric work, as well as carrying out specialist work, including fetal medicine, accepting country-wide referrals.

Bradford, Leeds and Huntingdon, 3–4 June 1991

Bradford:

1. Bradford Royal Infirmary (BRI) Maternity Unit:

   Planned that all local maternity services to be centralised on this site from 1994-5.

2. St. Luke's Maternity Hospital:

   Ante-natal services to continue after 1994-5. Special Care Baby Unit to move to the BRI, although a "stabilising" facility will remain, prior to a baby's transfer to BRI.

Leeds:

St. James's University Hospital:

Besides all usual maternity services, offers genetic counselling and preconception counselling service to discuss conditions including diabetes, cystic fibrosis, sickle cell anaemia and thalassaemia.

Huntingdon:

Hinchingbrooke Hospital:

Operates a consultant based medical staffing model, consultants, senior house officers, and hospital and community based midwives. There are no registrars or senior registrars.

Belfast, 10–11 June 1991

1. Royal Maternity Hospital:

   Provides midwifery services for the local community, and acts as regional referral centre for high risk obstetric and neo-natal cases. Offers a full range of maternity services facilities.

2. Jubilee Maternity, City Hospital:

   Discussions with senior clinicians centred on the higher incidence of congenital malformations in the Northern Ireland population compared to that of Great Britain.

3. Shankill Health Centre:

   Community health centre; includes chiropodist, dentist and speech therapist based on the premises, as well as doctors, community nurses, health visitors and midwives.

4. Department of Health and Social Services:

   Formal evidence at the City Hall, from the Permanent Secretary and other senior officials, including questions relevant to, *inter alia,* the inquiry. Published as HC (1990–91) 409-ii.

Sweden and the Netherlands, 24–28 June 1991

Sweden, 24–25 June:

1. MVC City Antenatal Clinic:

   Staffed by midwives. Provides ante-natal consultation and runs ante-natal classes for both partners, which includes parentcraft. Women attend the clinic eight weeks after delivering for a check-up, including gynaecological examination, and for family planning advice.

2. National Board of Health and Welfare:

   Overview of the provision of maternity services in Sweden.

3. Karolinska Hospital:

   Large teaching hospital. Regional centre for neonatal intensive care for the Stockholm area. Specialisms include treatment of diabetic women, referral centre for women with thrombo-embolic complications, IVF, stillbirth counselling service.

4. ABC Unit, South Hospital:

   Only natural birth centre in the country. Set up as a controlled research project, to assess the safety of offering natural childbirth, supervised by midwives only, for women of low medical risk.

(All meetings were held in Stockholm)

The Netherlands, 26–28 June:

1. Ministry of Welfare, Health and Cultural Affairs, The Hague:

   Overview of the provision of maternity services in the Netherlands.

2. National Association of Home Help Services, Bunnik:

   Presentation covering the history of the development of maternity care assistants, and describing how they work.

3. Hospital De Heel, Zaandam:

   Presentation regarding a study carried out in the Wormerveer area between 1969 and 1983, on the safety of obstetric care where midwives select pregnant women into groups with high and low risk.

4. Obstetrical Clinic Zaanstreek Noord, Wormerveer, and

5. Private homes in the Zaandam/Wormerveer area:

   Members divided into groups, and accompanied by midwives and medical staff, visited families where the mother had in the previous days given birth at home. Besides the mothers, fathers and babies, Members had the opportunity to meet the maternity care assistants working in each home.

6. Academic Medical Centre, University of Amsterdam:

   Teaching hospital, providing primary, secondary and tertiary care. Low risk deliveries were attended only by midwives. Majority of births were to high risk mothers, as the hospital was a regional referral centre. Large neo-natal department.

National Perinatal Epidemiology Unit, Radcliffe Infirmary, Oxford, 12 December 1991

Provides information which can promote effective use of resources in the perinatal health services. The two kinds of information required are descriptive for monitoring the services, and evaluative about the effects of care.

Bath Health Authority and South Wales, 17–18 December 1991

Bath Health Authority:

In 1990 of some 5,000 births in Bath District nearly a third took place in Neighbourhood Maternity Units. The Committee visited three of these GP Units, at Devizes Hospital, Trowbridge Hospital and the Greenways Maternity Unit of St. Andrew's Hospital, Chippenham.

Cardiff:

Welsh Health Planning Forum:

Formal evidence at the City Hall, from the Chairman and other senior officials. Published as HC (1991–92) 29-II.

Brecon:

Brecon War Memorial Hospital:

Community hospital which delivers over 90 per cent of pregnant women in the catchment area. Contains an operating theatre where elective and emergency sections are carried out. Screening and counselling services available.

Church Village, Pontypridd:

East Glamorgan General Hospital:

Base for the Rhondda Valley "Know Your Midwife" scheme. Midwives provide an integrated service based on self-managing teams. Hospital offers women a considerable degree of freedom to choose the way they wish to give birth.

One Member accompanied a midwife visiting some of her clients.

APPENDIX 2

FIGURES 1–12

FIGURE 1

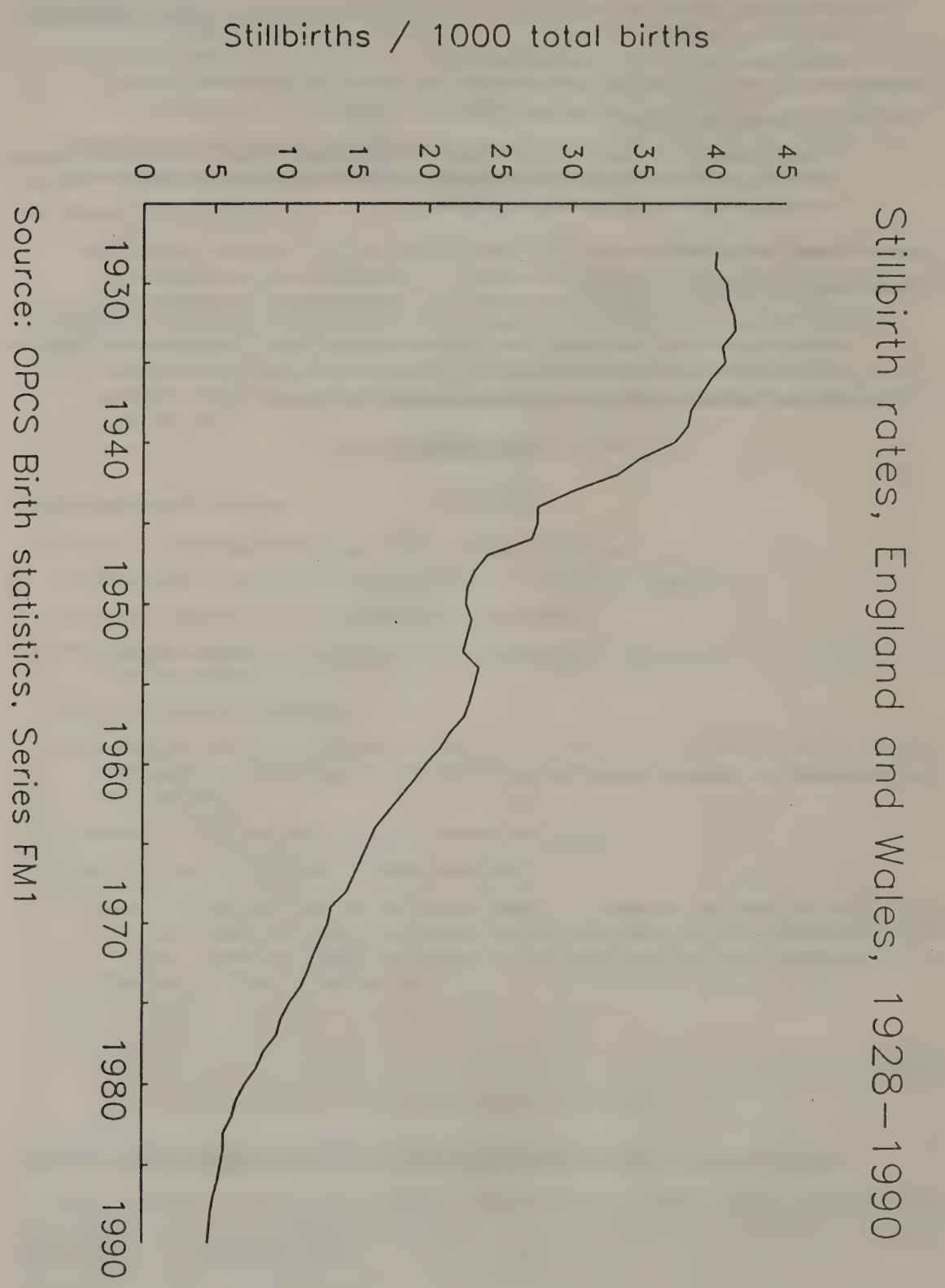

Stillbirth rates, England and Wales, 1928–1990
Stillbirths / 1000 total births
45
40
35
30
25
20
15
10
5
0
1930
1940
1950
1960
1970
1980
1990
Source: OPCS Birth statistics. Series FM1

FIGURE 2

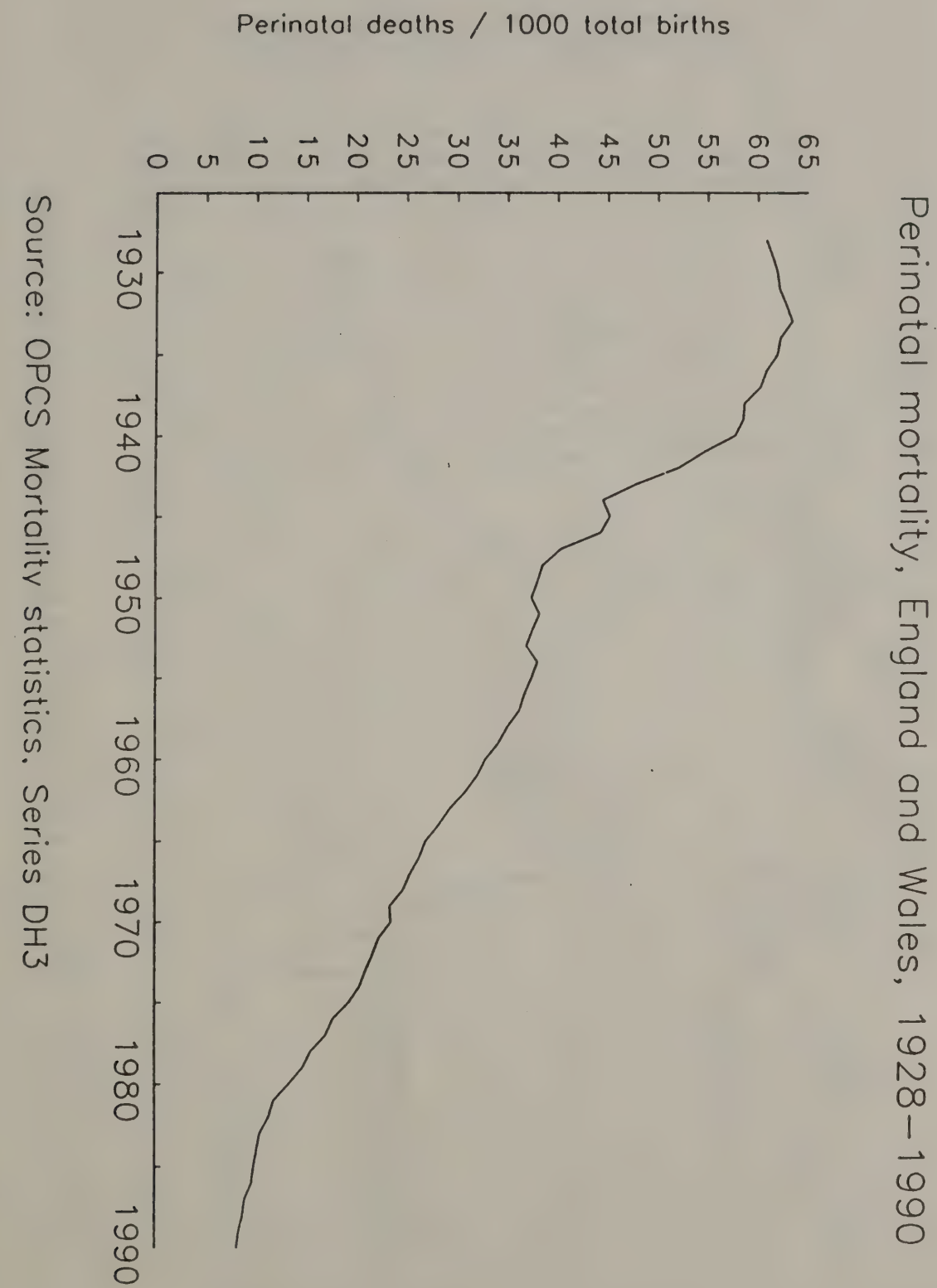

Perinatal deaths / 1000 total births
65
60
55
50
45
40
35
30
25
20
15
10
5
0
1930
1940
1950
1960
1970
1980
1990
Perinatal mortality, England and Wales, 1928–1990
Source: OPCS Mortality statistics, Series DH3

FIGURE 3

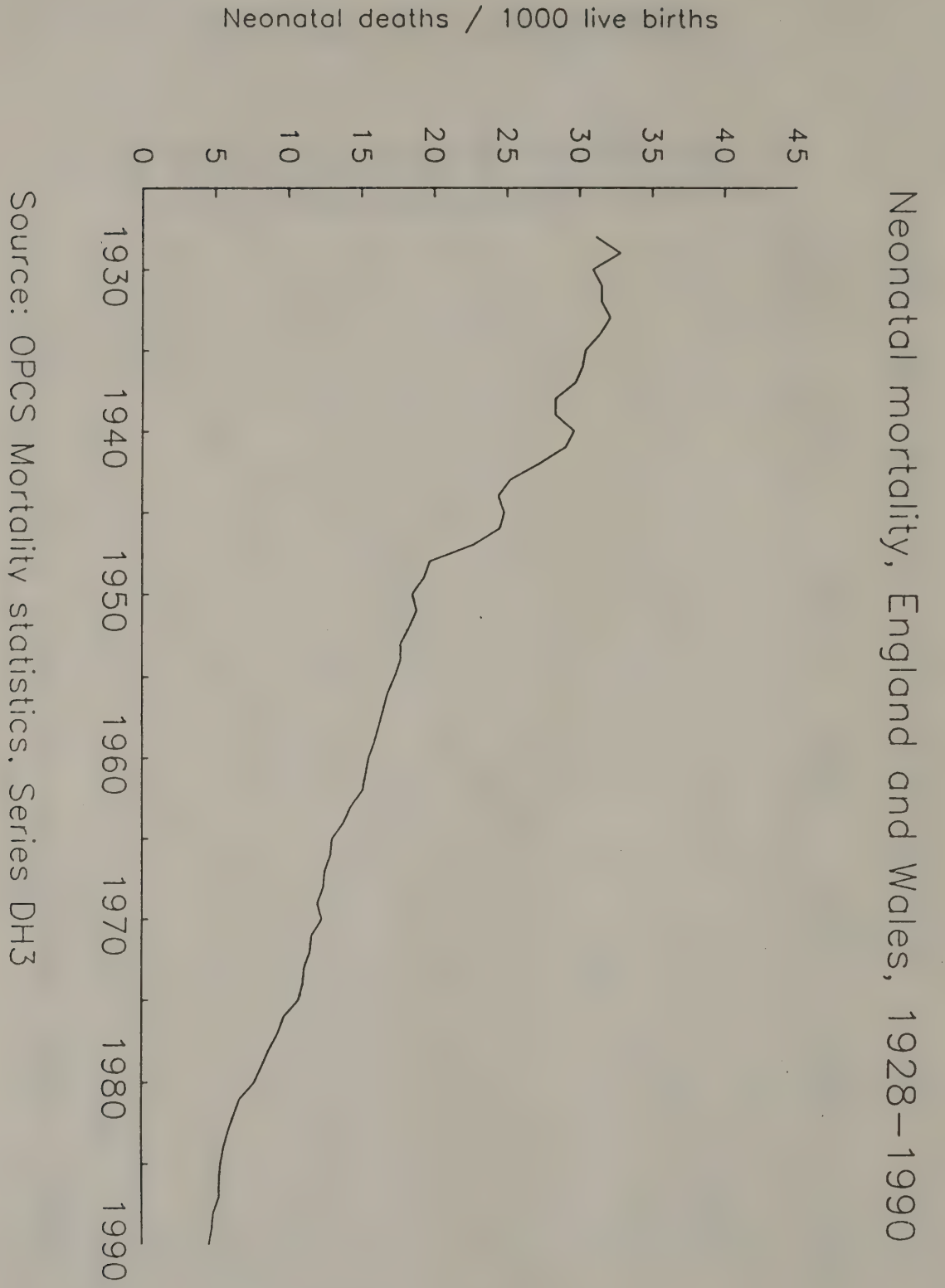
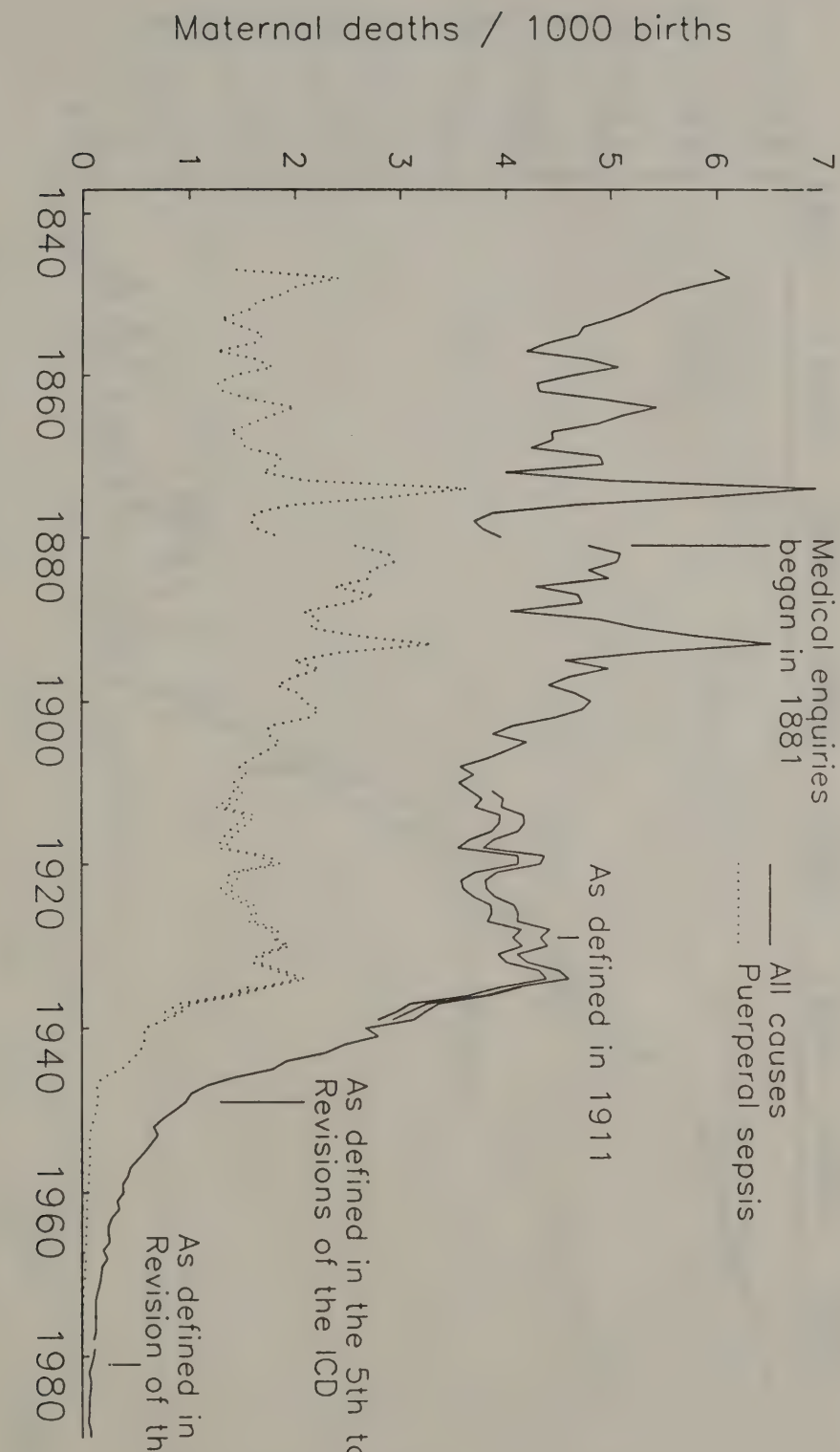

Neonatal deaths / 1000 live births
45
40
35
30
25
20
15
10
5
0
1930
1940
1950
1960
1970
1980
1990
Neonatal mortality, England and Wales, 1928–1990
Source: OPCS Mortality statistics, Series DH3

FIGURE 4



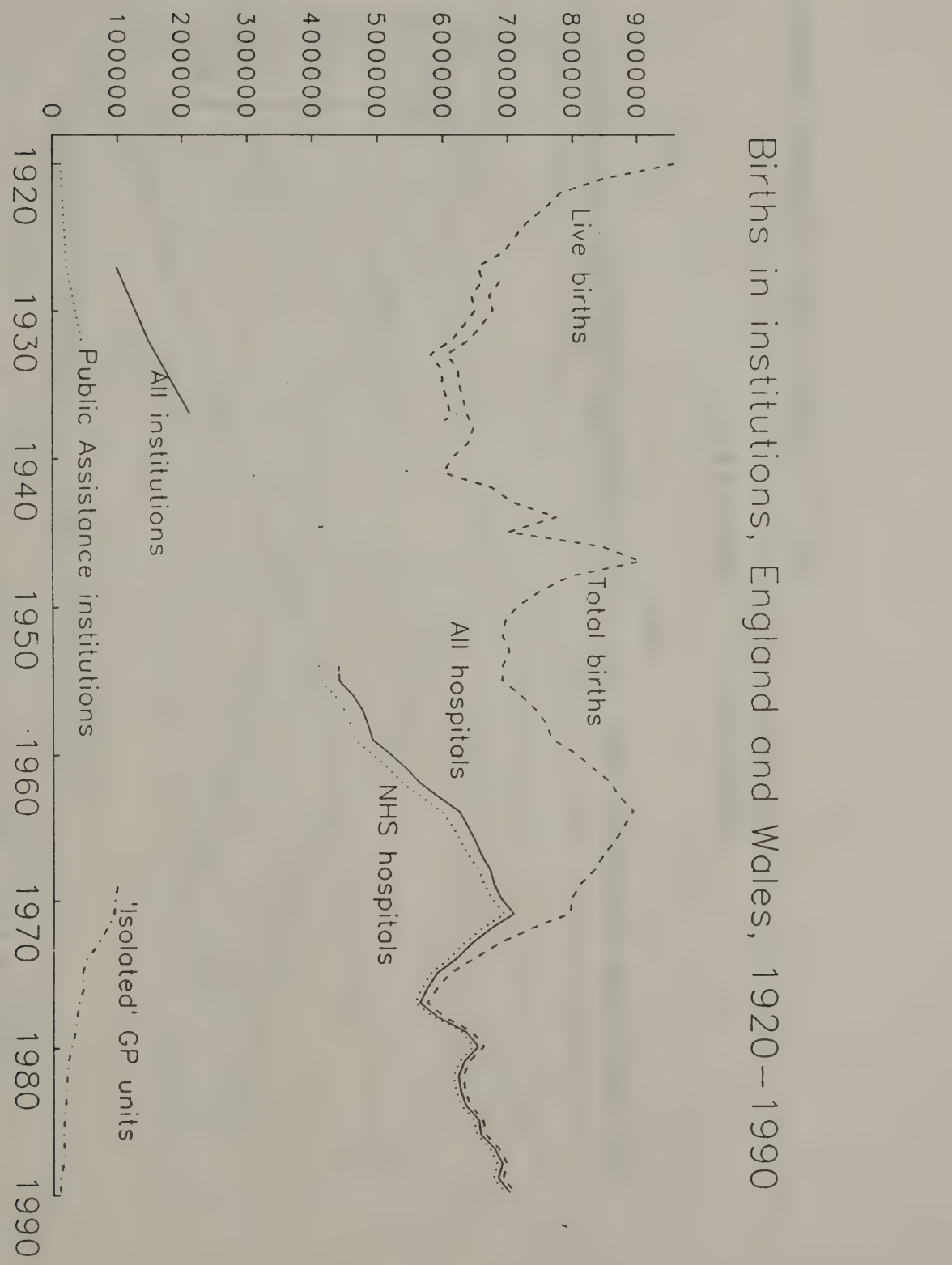
Source: OPCS Mortality statistics

FIGURE 5

Infant mortality, England and Wales, 1846–1990

Source: OPCS Mortality statistics

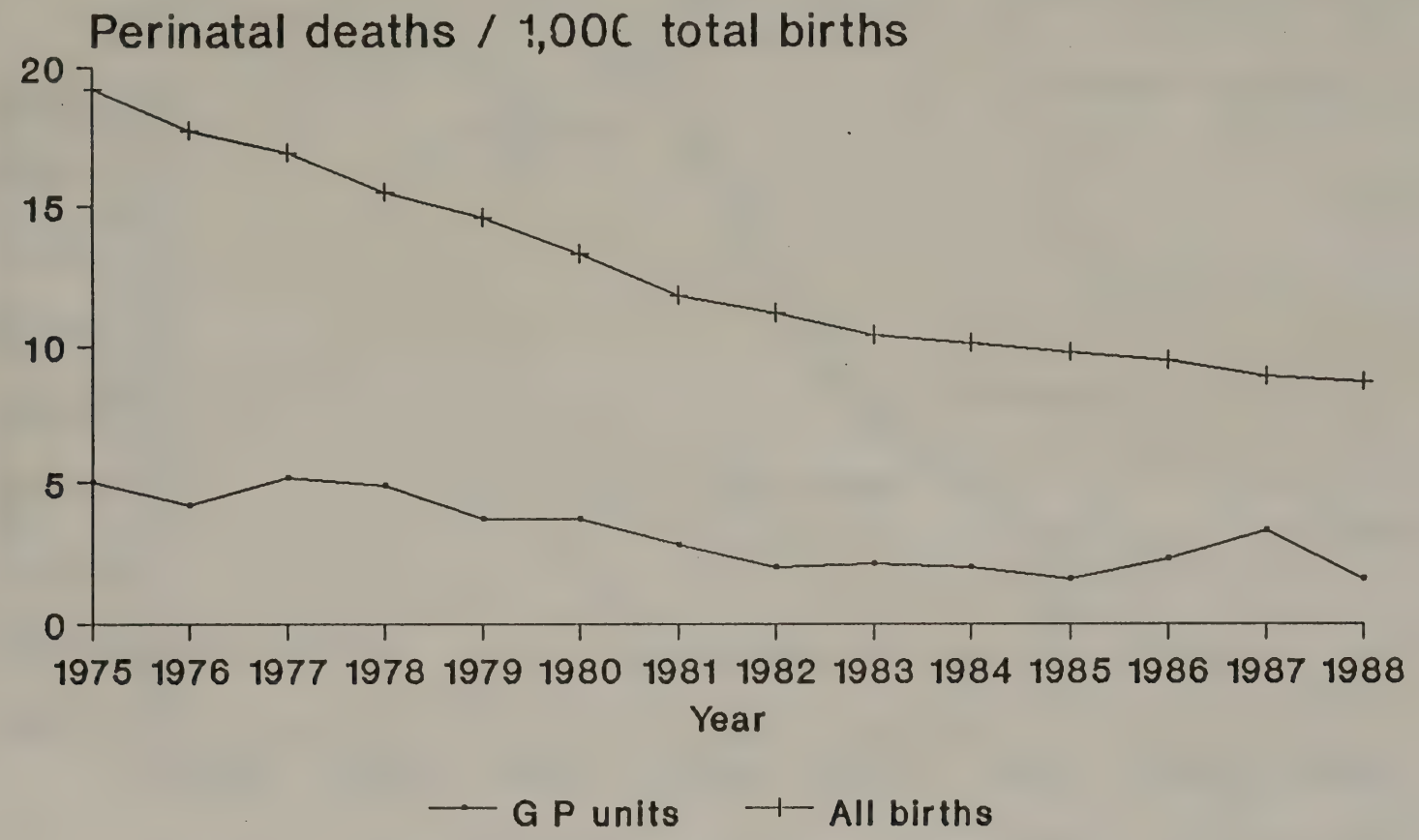
FIGURE 6



Source: OPCS Birth statistics

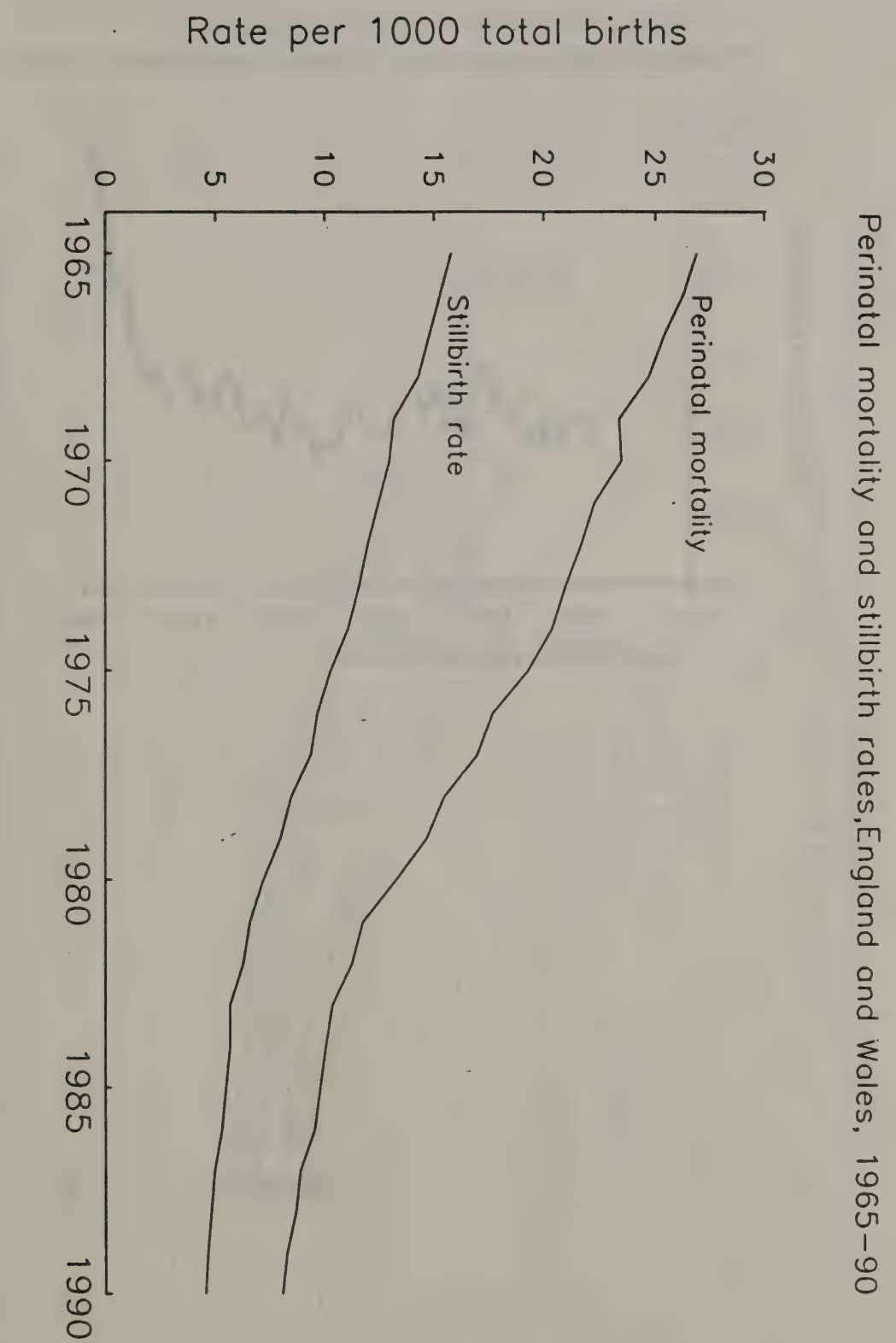
FIGURE 7

Perinatal mortality, England and Wales
Isolated units and all births, 1975-88



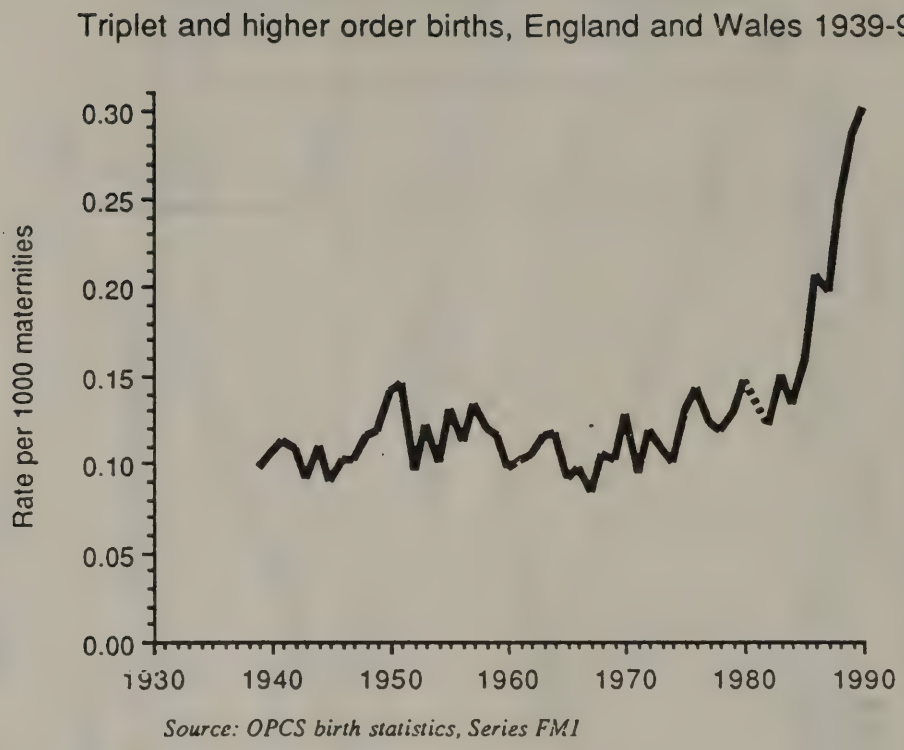
Source: OPCS mortality statistics, DH3

FIGURE 8



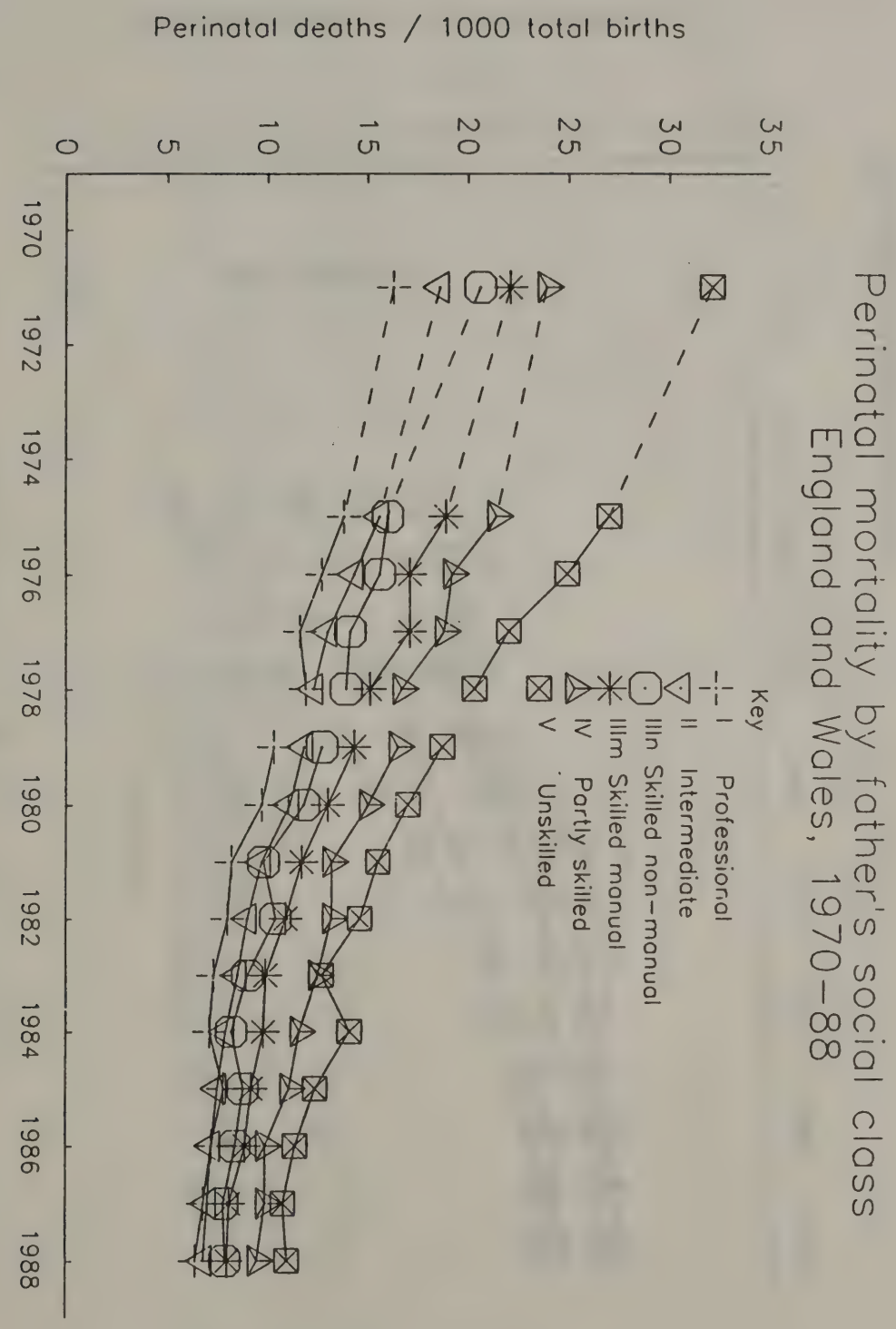
Source: OPCS Mortality statistics. Series DH3

FIGURE 9



Source: OPCS birth statistics, Series FM1

FIGURE 10



Source: OPCS Mortality statistics

FIGURE 11

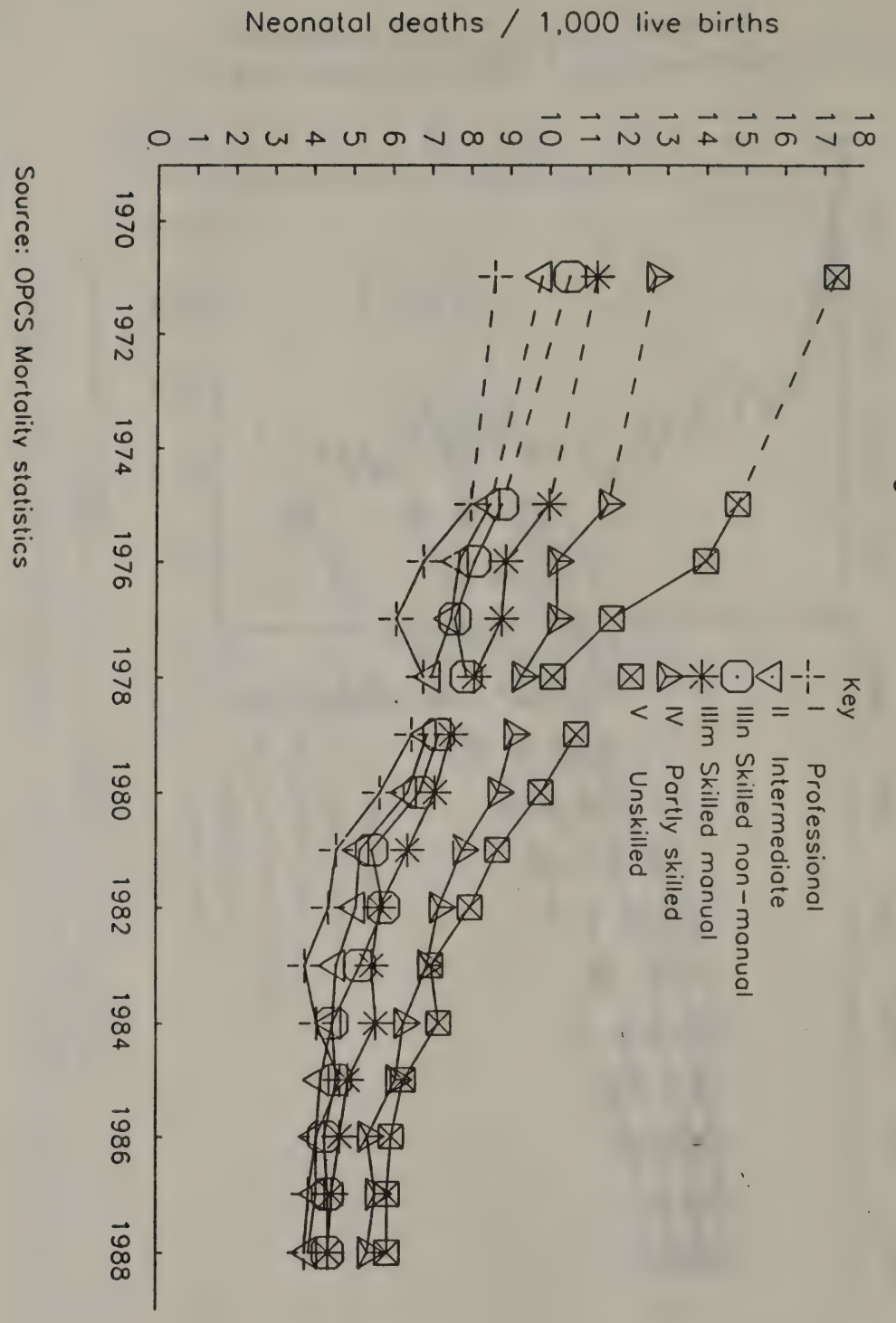
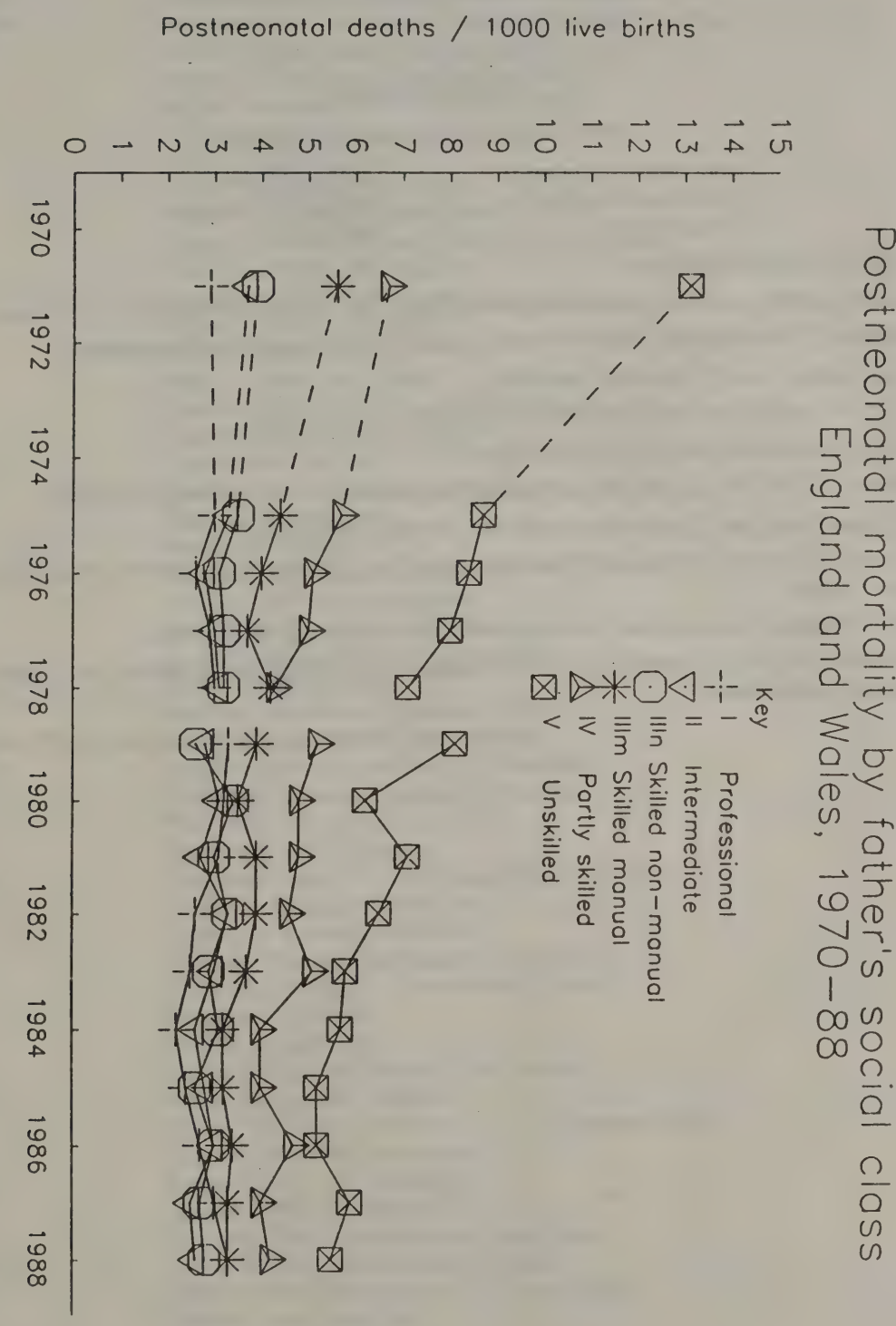

Neonatal deaths / 1,000 live births
Neonatal mortality by father's social class
England and Wales 1970–88
Key
I Professional
II Intermediate
IIIn Skilled non-manual
IIIm Skilled manual
IV Partly skilled
V Unskilled
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
1970 1972 1974 1976 1978 1980 1982 1984 1986 1988
Source: OPCS Mortality statistics

FIGURE 12


Postneonatal mortality by father's social class
England and Wales, 1970–88
Postneonatal deaths / 1000 live births
Key
I Professional
II Intermediate
IIIn Skilled non-manual
IIIm Skilled manual
IV Partly skilled
V Unskilled
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
1970 1972 1974 1976 1978 1980 1982 1984 1986 1988
Source: OPCS Mortality statistics

MINUTES OF PROCEEDINGS RELATING TO THE REPORT

Thursday 13 February 1992

Members present:

Mr Nicholas Winterton, in the Chair

Mr James Couchman	Sir David Price
Mr David Hinchliffe	Rev Martin Smyth
Alice Mahon	Audrey Wise

The Committee deliberated.

Draft Report, proposed by the Chairman, (Maternity Services), brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 453 read and agreed to.

List of Conclusions and Recommendations read and agreed to.

Appendices to the Report read and agreed to.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No 116 (Select Committees (reports)) be applied to the Report.

Several papers were ordered to be appended to the Minutes of Evidence.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.

[Adjourned till Wednesday next at a quarter to Four o'clock.

LIST OF ABBREVIATIONS USED IN THE REPORT

ACBMC	Association for Community-Based Maternity Care
ACHCEW	Association of Community Health Councils for England and Wales
AIMS	Association for Improvements in Maternity Services
AVMA	Action for Victims of Medical Accidents
BAPM	British Association of Perinatal Medicine
BMA	British Medical Association
BMJ	British Medical Journal
BPA	British Paediatric Association
BPPA	British Perinatal Pathology Association
CCSC	Central Consultants and Specialists Committee
CHC	Community Health Council
DE	Department of Employment
DGH	District General Hospital
DH	Department of Health
DHA	District Health Authority
DHSS	Department of Health and Social Security
DSS	Department of Social Security
Domino	Domiciliary In–Out
FSHA	Family Services Health Authority
GP	General Practitioner
HA	Health Authority
HES	Hospital Episode Statistics
HIPE	Hospital In-Patient Episodes
IC	Intensive Care
JPAC	Joint Planning Advisory Committee
JWP	Joint Working Party
MLSO	Medical Laboratory Scientific Officer
MRC	Medical Research Council
MSAC	Maternity Services Advisory Committee
MSLC	Maternity Services Liaison Committee
NCT	National Childbirth Trust
NHS	National Health Service
NHSME	National Health Service Management Executive
NICU	Neonatal Intensive Care Unit
NNA	Neonatal Nurses Association
NPEU	National Perinatal Epidemiology Unit
OPCS	Office of Population Censuses and Surveys
PND	Prenatal Diagnosis
PNM	Perinatal Mortality
RCGP	Royal College of General Practitioners
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians and Gynaecologists
RCP	Royal College of Physicians
RCPath	Royal College of Pathologists
RHA	Regional Health Authority
RPAC	Regional Perinatal Advisory Committee
SANDS	Stillbirth and Neonatal Death Society
SATFA	Support After Termination for Abnormality
SCBU	Special Care Baby Unit
SHO	Senior House Officer
TAMBA	Twins and Multiple Births Association
UGC	University Grants Council (now UFC)
VBAC	Vaginal Birth After Caesarian
VLBW	Very Low Birthweight

LIST OF WITNESSES

Session 1990–91

The oral evidence taken in this Session was published in separate daily volumes. For ease of reference, it was reissued in a single volume, HC (1990–91) 430–II.

Wednesday 8 May 1991

Mr Arthur Wynn, Mrs Margaret Wynn and Dr Jean Golding.

THE INSTITUTE OF BRAIN CHEMISTRY AND HUMAN NUTRITION AND THE LITTLE FOUNDATION

Professor Michael Crawford, Ms Wendy Doyle, Dr Kate Costeloe and Mr Ian Dawson-Shepherd. HC (1990–91) No. 430-i.

Wednesday 15 May 1991

Dr Jean Chapple, Dr Dian Donnai and Professor Norman Nevin.

Dr Geoffrey Marsh, Miss Christine Bradley, Ms Catherine Nightingale and Dr Mary Hepburn. HC (1990–91) No. 430-ii.

Wednesday 22 May 1991

THE MATERNITY ALLIANCE

Ms Lynette Murray, Ms Angela Phillips, Ms Akgul Baylav, Ms Meg Goodman, Ms Christine Gowdridge and Ms Veronica Lewis.

THE HEALTH EDUCATION AUTHORITY

Dr Spencer Hagard, Dr Brian Cooke and Ms Kathy Elliott. HC (1990–91) No. 430-iii.

Wednesday 12 June 1991

ROYAL COLLEGE OF MIDWIVES

Miss Margaret Brain, OBE, Miss Ruth M. Ashton, Miss Beverley Bryans, Miss Anne Rider and Ms Lesley Page.

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

Mr Stanley C. Simmons, Miss Mary Anderson, Professor Richard Beard, Professor William Dunlop and Miss Heather Mellows. HC (1990–91) 430-iv.

Wednesday 3 July 1991

DEPARTMENT OF HEALTH

Dr Diana Walford, Mr John Shaw, Mr Norman Hale, Dr John Modle, Mr John Sharpe and Miss Joan Greenwood. HC (1990–91) 430-v.

Wednesday 10 July 1991

ROYAL COLLEGE OF GENERAL PRACTITIONERS

Dr Colin Waine OBE.

NATIONAL CHILDBIRTH TRUST

Ms Eileen Hutton, Ms Mary Newburn, Ms Mary Barnard, Ms Jill Aitken, Ms Helen Lewison and Ms Sue Bruton. HC (1990–91) 430-vi.

Session 1991–92

The oral evidence taken in this Session was not published in separate daily volumes. It is being issued in a single volume. HC (1991–92) 29-II.

Wednesday 6 November 1991

DEPARTMENT OF HEALTH

Mrs Virginia Bottomley MP, Dr Diana Walford, Mr John Shaw, Dr Ian Lister-Cheese and Miss Joan Greenwood.

TRENT REGIONAL HEALTH AUTHORITY

Mr Brian Edwards.

Wednesday 13 November 1991

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

Mr Stanley C. Simmons, Miss Mary Anderson and Professor William Dunlop.

ROYAL COLLEGE OF MIDWIVES

Miss Margaret Brain OBE, Miss Ruth M. Ashton, Miss Beverley Bryans, Miss Anne Rider and Ms Lesley Page.

Wednesday 20 November 1991

BRITISH ASSOCIATION OF PERINATAL MEDICINE

Professor Richard Cooke and Professor Malcolm Levene.

BRITISH PAEDIATRIC ASSOCIATION

Professor David Hull.

NEONATAL NURSES' ASSOCIATION

Mrs Win Huxton and Ms Paula Hale.

THAMES REGIONAL PERINATAL GROUP

Dr Rodney Rivers and Dr Patricia Hamilton.

Wednesday 27 November 1991

DEPARTMENT OF SOCIAL SECURITY

Mrs Susan Maunsell, Mr Peter Tansley and Mr Bob Layton.

ASSOCIATION FOR IMPROVEMENTS IN MATERNITY SERVICES

Ms Beverley Lawrence Beech, Ms Christine Rodgers and Mrs Jean Robinson.

Wednesday 4 December 1991

BRITISH PAEDIATRIC PATHOLOGY ASSOCIATION

Dr Ian Rushton and Professor Jonathan Wigglesworth.

SUPPORT AFTER TERMINATION FOR ABNORMALITY

Ms Joanie Dimavicius and Ms Helen Statham.

STILLBIRTH AND NEONATAL DEATH SOCIETY

Ms Roma Iskander and Ms Nancy Kohner.

Wednesday 11 December 1991

OFFICE OF POPULATION CENSUSES AND SURVEYS

Ms Karen Dunnell, Mrs Beverley Botting and Professor Eva Alberman.

Mrs Marjorie Tew.

ASSOCIATION FOR COMMUNITY-BASED MATERNITY CARE

Dr Gavin Young, Dr David Jewell, Mrs Marion Mckenzie, Mr Richard Porter and Dr Sandy Cavenagh.

Tuesday 17 December 1991

WELSH HEALTH PLANNING FORUM

Mr John Wyn Owen, Dr Morton Warner, Dr Bernadette Fuge, Mrs Sheila Drayton, Mr Derek Adams and Mr David Pritchard.

Thursday 16 January 1992

DEPARTMENT OF HEALTH

Mrs Virginia Bottomley MP, Dr Diana Walford, Dr John Modle, Mr John Sharpe and Miss Joan Greenwood.

TRENT REGIONAL HEALTH AUTHORITY

Mr Brian Edwards.

Ms Linda Gartland, Ms Deborah Hedderwick, Ms Cressida Nash, Ms Helen Robinson, Ms Ruth Unwin, Mr Patrick Turner and Mr David Johnstone.

LIST OF MEMORANDA RECEIVED

Please note: this list does not include published books, articles etc, received by the Committee, and which are available elsewhere.

Ref. No.	*Source*	*Published in*
MS3	Stillbirth and Neonatal Death Society	HC (1991-92) 29-II
MS5	Mr and Mrs Arthur Wynn	HC (1990-91) 430-II
*MS6	National Association for the Childless	—
*MS7	Dr M de Swiet	—
MS8	Miss C M Bradley, Midwife Teacher, Stepping Hill Hospital, Stockport	HC (1990-91) 430-II
MS9	Dr Geoffrey N Marsh	HC (1990-91) 430-II
MS10	Mrs C Rickitt, Director of Midwifery, Sunderland Health Authority	HC (1990-91) 430-III
MS11	Ms Jean Davies	HC (1991-92) 29-III
MS12	Professor Malcolm Levene, Head of Department of Paediatrics and Child Health, University of Leeds	HC (1991-92) 29-II
MS13	Institute for Social Studies in Medical Care	HC (1990-91) 430-III
MS14	Ms Stephanie Ward	HC (1991-92) 29-III
MS15	Mr and Mrs M. Fisher	HC (1991-92) 29-III
MS16	Mrs Marjorie Tew	HC (1991-92) 29-II
MS17	Association for Post Natal Illness	HC (1991-92) 29-III
MS18	Mrs Lynden Bowen	HC (1991-92) 29-III
*MS20	Geraldine Stevens	—
MS21	Vivien Sleeman	HC (1991-92) 29-III
MS22	Dr Dian Donnai	HC (1990-91) 430-II
*MS23	Dr Kenneth Barlow	—
MS25	Jane Gillett SRN SCM	HC (1990-91) 430-III
MS26	English National Board for Nursing, Midwifery and Health Visiting	HC (1991-92) 29-III
MS27	Association of Supervisors of Midwives	HC (1991-92) 29-III
MS28	Mrs Betty Binysh	HC (1991-92) 29-III
MS29	Miscarriage Association	HC (1991-92) 29-III
MS30	The Little Foundation	HC (1990-91) 430-II
MS31	Mr J M Pearce, St George's Hospital Medical School	HC (1990-91) 29-III
MS33	Clinical Genetics Society	HC (1990-91) 430-II
MS34	Institute of Brain Chemistry and Human Nutrition	HC (1990-91) 430-II
MS35	Ms Moira Johnson	HC (1991-92) 29-III
MS36	Mrs G P McKee	HC (1991-92) 29-III
MS37	Mrs R F Heeks	HC (1991-92) 29-III
MS38	United Kingdom Central Council for Nursing, Midwifery and Health Visiting	HC (1991-92) 29-III
*MS39	Valerie Immonen	—
*MS40	Dr B M Pickard	—
*MS41	Hyperactive Children's Support Group	—
MS42	Maternity Services Research Group, University of Cambridge	HC (1991-92) 29-III
MS43	Mrs Elizabeth Carter	HC (1991-92) 29-III
MS44	Support After Termination for Abnormality	HC (1991-92) 29-II
MS45	Professor M J Whittle	HC (1990-91) 430-III
*MS46	Ms Anne Jackson-Baker	—
MS47	Association for General Practice Maternity Care	HC (1991-92) 29-II
MS48	Association of Breastfeeding Mothers	HC (1991-92) 29-III
MS49	Dr Jean Chapple, North West Thames RHA	HC (1990-91) 430-II
MS50	National Perinatal Epidemiology Unit	HC (1991-92) 29-III
MS51	Dr Jean Golding	HC (1990-91) 430-II
MS52	Twins and Multiple Births Association	HC (1991-92) 29-III
MS53	Midwives Information and Resource Service	HC (1991-92) 29-III
MS54	VBAC Information and Support Group	HC (1991-92) 29-III
MS56	Wendy Savage	HC (1990-91) 430-III

Ref. No.	*Source*	*Published in*
MS57	Women's Health Care Research Unit, Joint Medical Colleges of St Bartholomews and the London Hospitals	HC (1991-92) 29-III
MS58	Ms Valerie Taylor	HC (1991-92) 29-III
MS59	Susan Edberg	HC (1991-92) 29-III
*MS60	Margaret Reid, Department of Community Medicine, Glasgow University	—
MS61	General Medical Services Committee of the BMA ...	HC (1990-91) 430-III
MS62	Royal College of Midwives	HC (1990-91) 430-II
*MS63	Mrs A Revell	—
MS64	Division of Community Health, United Medical and Dental Schools of Guy's and St Thomas's Hospitals	HC (1991-92) 29-III
MS65	Foresight	HC (1990-91) 430-III
MS66	Central Consultants and Specialists Committee of the BMA	HC (1990-91) 430-III
*MS67	Professor C H Rodeck	—
MS68	Professor E M Symonds	HC (1990-91) 430-III
MS69	Mrs N J Taylor	HC (1991-92) 29-III
*MS70	Dr Ellen C G Grant	—
MS71	Miss Sarah Roch, Southampton University College of Nursing and Midwifery	HC (1991-92) 29-III
*MS72	Society for the Protection of Unborn Children	—
MS73	Professor A A Calder, Dr F D Johnstone and Dr W A Liston, University of Edinburgh	HC (1991-92) 29-III
MS74	Royal College of Obstetricians and Gynaecologists ...	HC (1990-91) 430-II
MS75	The National Childbirth Trust	HC (1990-91) 430-II
MS76	Association of Radical Midwives	HC (1991-92) 29-III
MS77	Ms C Nightingale, Maternity Services Manager, Hillingdon Hospital, Uxbridge	HC (1990-91) 430-II
MS78	Mrs E J Shakespeare	HC (1991-92) 29-III
MS79	Mr R Fawdry	HC (1991-92) 29-III
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MS84	Sally Rose	HC (1991-92) 29-III
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MS86	Dr Marion Hall, University of Aberdeen	HC (1991-92) 29-III
MS87	Jean Keats	HC (1990-91) 430-III
MS88	Anne C E Rider	HC (1991-92) 29-III
MS89	Department of Health	HC (1990-91) 430-II
MS90	Department of Health	HC (1990-91) 430-II
MS91	Medical Research Council	HC (1991-92) 29-III
*MS92	Professor J M G Harley, Royal Maternity Hospital, Belfast	—
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MS110	Professor Sir Malcolm Macnaughton	HC (1991-92) 29-III

Ref. No.	*Source*	*Published in*
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*MS122	Bedford General Hospital	—
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MS129	Mrs J Humphrey	HC (1991-92) 29-III
*MS130	Professor Geoffrey Chamberlain	—
MS132	Dr C W G Redman	HC (1991-92) 29-III
MS133	Mrs Marjorie Tew	HC (1991-92) 29-II
MS134	Mary Cronk	HC (1991-92) 29-III
MS135	British Paediatric Association Standing Committee on Immunisation and Infectious Disease	HC (1990-91) 430-III
*MS137	Conservative Family Campaign	—
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MS143	Professor Alan A Jackson	HC (1991-92) 29-III
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MS145	Waltham Forest Health Authority	HC (1991-92) 29-III
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MS147	Brook Advisory Centres	HC (1990-91) 430-III
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*MS149	British Association of Social Workers	—
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*MS156	VBAC Information and Support Group	—
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MS162	Royal College of General Practitioners	HC (1990-91) 430-II
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MS164	British Association for Perinatal Medicine	HC (1991-92) 29-II
MS165	BLISS (Baby Life Support Systems)	HC (1991-92) 29-III
MS167	General Medical Services Committee of the BMA ...	HC (1991-92) 29-III
*MS168	Senior Midwives at Royal Shrewsbury Maternity Hospital	—
*MS169	Letter to Sir Fergus Montgomery MP from Mrs Anne Willig	—
MS171	Dr Kate Costeloe	HC (1990-91) 430-II
*MS172	Mrs Pauline Quinn	—

Ref. No.	*Source*	*Published in*
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MS177	Yvonne Stone...	HC (1991-92) 29-III
MS178	Neonatal Nurses Association	HC (1991-92) 29-II
*MS179	Society for the Protection of Unborn Children	—
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MS182	Royal College of Obstetricians and Gynaecologists ...	HC (1990-91) 430-II
MS183	British Paediatric Association	HC (1991-92) 29-II
*MS184	Mrs Susan Ward, Rochdale Health Authority	—
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MS186	Consumers for Ethics in Research (CERES)	HC (1991-92) 29-III
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*MS190	Hammersmith & Queen Charlotte's Special Health Authority	—
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MS192	National Childbirth Trust	HC (1990-91) 430-II
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MS194	Royal College of Nursing	HC (1991-92) 29-III
MS195	Royal College of Midwives	HC (1990-91) 430-II
MS196	Stillbirth and Neonatal Death Society	HC (1991-92) 29-II
MS197	Dr Geoffrey N Marsh	HC (1990-91) 430-II
MS198	Twins and Multiple Births Association	HC (1991-92) 29-III
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*MS203	Standing Conference of Voluntary Organisations for People with a Mental Handicap in Wales	—
*MS204	The Foundation for the Study of Infant Deaths	—
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MS206	Dr L F P Smith, Department of Epidemiology and Public Health Medicine, University of Bristol	HC (1991-92) 29-III
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MS213	Association for Post-Natal Illness	HC (1991-92) 29-III
MS214	Mrs N J Taylor	HC (1991-92) 29-III
MS215	Jacqui Stearn	HC (1991-92) 29-III
MS216	Camberwell Community Health Council	HC (1991-92) 29-III
MS218	Sally Rose	HC (1991-92) 29-III
MS219	Maternity Alliance	HC (1990-91) 430-II
MS220	Senior Midwives, University College Hospital	HC (1991-92) 29-III
MS221	Karen Wilde	HC (1991-92) 29-III
*MS222	Mr D R S Bols	—
MS223	British Dietetic Association	HC (1991-92) 29-III
MS224	Women in Gynaecology and Obstetrics	HC (1991-92) 29-III
MS225	Maternity Alliance	HC (1990-91) 430-II
MS226	Royal College of Nursing	HC (1991-92) 29-III
MS228	Dr Dian Donnai	HC (1990-91) 430-II
*MS230	Genetic Interest Group	—

Ref. No.	*Source*	*Published in*
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*MS245	Jan Barnes	—
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MS268	Department of Health	HC (1990-91) 430-II
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MS285	Royal College of Midwives Belfast Branch...	HC (1991-92) 29-III
MS288	Stillbirth and Neonatal Death Society	HC (1991-92) 29-II
*MS289	Letter to Ruth Ashton, Royal College of Midwives from Dr Barrie Kenyon	—
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MS293	Department of Health	HC (1991-92) 29-II
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MS299	South Lincolnshire Community Health Council	HC (1991-92) 29-III
MS302	Department of Health	HC (1991-92) 29-II
MS303	The Revd Paul Ferguson	HC (1991-92) 29-III
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*MS310	Mrs Julia Allison	—
*MS311	Action on Pre-Eclampsia	—
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*MS318	British Association of Social Workers, Scottish Office	—
MS319	Dr Richard Porter, Royal United Hospital, Bath	HC (1991-92) 29-II
MS320	Department of Health	HC (1990-91) 430-III HC (1991-92) 29-II
*MS321	Letter to Audrey Wise MP from Mrs Linda Stephens	—
MS322	Neonatal Nurses Association	HC (1991-92) 29-II
MS325	Dr Colin Stern	HC (1991-92) 29-III
*MS327	Isle of Wight Branch of RCM	—
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*MS331	D S Butler, Save Andover Maternity Unit	—
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*MS364	Mrs D M Fraser, Mid Trent College of Nursing and Midwifery	—
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MS371	Dr S E Browne	HC (1991-92) 29-III
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*MS387	Wendy Savage	—
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MS391	Letter to Dr Ian Bogle from Dr P S Larkin	HC (1991-92) 29-III
MS394	Association for Community-Based Maternity Care	HC (1991-92) 29-II
*MS395	Mrs Elaine Emmons	—
MS397	Mr J H MacDonald	HC (1991-92) 29-III
MS399	Mary Cronk	HC (1991-92) 29-III
MS400	Ms D Lloyd	HC (1991-92) 29-III
MS401	AIMS	HC (1991-92) 29-II
*MS402	Medical Executive Committee of the South Gwent Acute Unit	—
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MS408	Mrs Mary Tyler	HC (1991-92) 29-III
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MS417	Department of Social Security	HC (1991-92) 29-II
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MS419	Royal College of Midwives	HC (1991-92) 29-III
MS420	Miss Margaret A Bourne	HC (1991-92) 29-III
*MS421	Genetic Interest Group	—
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*MS426	Huntleigh Healthcare	—
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*MS436	Director of Public Health, South Cumbria HA	—
*MS440	BMA	—
*MS442	Mrs Brenda van der Kooy	—
*MS443	Association for Community-Based Maternity Care	—

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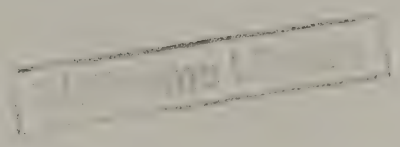

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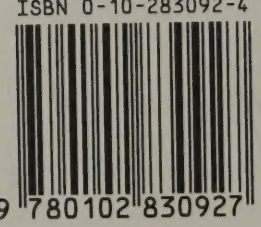

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